S. HRG. 103–459

HEALTH CARE REFORM: DO ANTITRUST LAWS DISCOURAGE COST CUTTERS OR DEFEAT PRICE GOUGERS?

HEARING

BEFORE THE

SUBCOMMITTEE ON ANTITRUST, MONOPOLIES AND BUSINESS RIGHTS

OF THE

COMMITTEE ON THE JUDICIARY UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

EXAMINING THE ROLE OF FEDERAL ANTITRUST LAWS AND ENFORCEMENT POLICIES IN HEALTH CARE REFORM, FOCUSING ON COST CONTAINMENT PROPOSALS

MARCH 23, 1993

Serial No. J–103–6

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HEALTH CARE REFORM: DO ANTITRUST LAWS DISCOURAGE COST CUTTERS OR DEFEAT PRICE GOUGERS?

TUESDAY, MARCH 23, 1993

U.S. SENATE,
SUBCOMMITTEE ON ANTITRUST, MONOPOLIES
AND BUSINESS RIGHTS,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room SD–226, Dirksen Senate Office Building, Hon. Howard M. Metzenbaum (chairman of the subcommittee) presiding.

Also present: Senators Thurmond and Hatch.

OPENING STATEMENT OF HON. HOWARD M. METZENBAUM, A U.S. SENATOR FROM THE STATE OF OHIO

Senator METZENBAUM. The subcommittee will come to order. I apologize for being a few minutes late.

Health care reform is long overdue, and I am optimistic we will soon be able to fix a health care system that has failed millions of Americans. I was particularly struck by a recent poll in the Wall Street Journal which found that 66 percent of the American people are so concerned about the inadequacy of the health care system that they are willing to pay higher taxes.

However, I am concerned that the marvelous spirit of sacrifice reflected in the Journal's poll may not be shared by those who have profited so handsomely from our health care system—the doctors, the hospitals, and the drugmakers. I am particularly skeptical of their clarion calls for weakening our Nation's fair competition laws. These groups complain that they are caught in an inherent conflict between antitrust policy and health policy. On one hand, health policy encourages them to collaborate, while on the other hand antitrust policy threatens those collaborations.

I do not believe there is an inherent conflict between antitrust and health policy. The goal of both is the same, to provide consumers with high-quality health care at affordable prices. Moreover, the need for a strong antitrust enforcement policy could be even greater if we move to a health care system based on managed competition.

As I understand it, managed competition is based on the premise that medical prices will fall if health care providers are forced to compete on the basis of price and quality. If that is true, then managed competition could fail if we weaken the antitrust laws. Doc-

tors, hospitals, and drugmakers are not just ordinary businesses facing an uncertain future. Some of them may have well-founded concerns about antitrust enforcement. I think it is appropriate that today we explore those concerns.

The American Hospital Association, the AHA, has complained that antitrust enforcement is chilling procompetitive mergers and joint ventures because it is incompatible with the way hospital markets operate. To remedy the problem, the AHA has suggested that the Department of Health and Human Services be permitted to exempt hospital deals from antitrust scrutiny. Frankly, the evidence suggests that AHA claims on antitrust-related chill are overstated and that their proposal to give HHS antitrust exemption authority is a bad one. Let me explain.

There have been comparatively few enforcement actions taken against hospital deals. Since 1987, there have been over 225 hospital mergers. Of that number, only 22 have required intensive second-request investigations, and only 7 have been challenged. There have been no challenges to joint ventures or other collaborative arrangements.

Furthermore, public statements by AHA officials do not support their lobbyists' claims that antitrust enforcement has chilled hospital deals. For example, in the March 15 AHA News, AHA President Richard Davidson is quoted as saying that "there is more collaboration going on in communities than we ever imagined."

Another concern that AHA has raised is that hospital markets do not respond well to competition. However, there is some persuasive evidence that competition does, in fact, result in lower prices and better quality in hospital markets. For example, a study published in the Journal of Economics stated that "actual hospital prices are lower in more competitive markets."

Some experts argue that hospitals in rural areas may not benefit from competition. I would expect those arguments to be considered before a merger in a rural area is challenged. However, until it is proven otherwise, I believe that we should proceed on the assumption that too much consolidation in a hospital market can be costly for consumers.

Finally, AHA's proposal to give HHS antitrust exemption authority is a bad one. A recent report by an internal HHS task force reached the same conclusion after studying the Department's policy on hospital mergers. The task force recommended that the Department oppose legislation that would compel it to approve hospital mergers.

In short, there is little persuasive evidence that the antitrust laws are chilling hospital deals or that hospitals need special antitrust treatment.

Doctors' groups have also complained about antitrust enforcement. Unlike hospitals, however, doctors have frequently been the target of antitrust enforcement actions. The fact is that doctors have an astonishing record of violating the antitrust laws going back to 1943 when they boycotted the formation of a Washington, DC, HMO. The antitrust laws defeated these collusive boycotts and paved the way for HMO's to enter the market.

Likewise, doctor groups have been prosecuted for agreements to prevent a hospital from developing an urgent care center and to

prevent a medical school from hiring full-time doctors. They have also been charged with denying credentials to the employees of a new medical clinic and with refusing to provide emergency room services until a hospital paid them to take calls. This is by no means an exhaustive list.

Despite an extensive record of antitrust infractions, the American Medical Association has petitioned the FTC and the Congress for special antitrust protection for physicians. The AMA wants to immunize doctors' groups that negotiate with large purchasers such as insurance companies and HMO's. According to the AMA, doctors should have the right to bargain collectively to counterbalance the power that large purchasers have over individual doctors.

However, the conduct permitted under the AMA's legislative proposal could include the kind of per se illegal price-fixing that was prosecuted in *United States* v. *Alston.* A closer look at that case suggests that the AMA's proposal could be very costly for consumers.

In *Alston,* the Department of Justice prosecuted three Arizona dentists who agreed to increase patient copayments, which is the amount that patients have to pay out of pocket for dental services. These dentists and about 30 of their colleagues agreed to send letters to four dental plans demanding that patient copayments be increased. The result of this conspiracy was that three of the plans agreed to increase patient copayments and one complained to the Government.

The fact is that doctors are allowed to negotiate collectively if they are members of a legitimate preferred provider organization. To qualify for protection, members must contribute capital to or share some financial risk in the organization. In other words, the doctors must have some tangible incentive to act more like a single entity than a group of price-fixing competitors.

I do not believe that doctors need special antitrust protection to negotiate with large purchasers, and I would strongly oppose any proposal that permitted physicians to price-fix as the dentists did in Arizona. Immunizing that kind of conduct would completely undermine the cost containment goals of health care reform and send prices right through the roof.

The most recent group to ask for special antitrust treatment is the Pharmaceutical Manufacturers Association, otherwise known as PMA. PMA has requested immunity from antitrust prosecution for an agreement among its member companies to limit price increases. It sounds good on its face, not so good in reality.

Last Thursday, Senator Pryor and I sent a letter to Attorney General Janet Reno urging her to reject the PMA's request. In the letter, we commended PMA for acknowledging publicly that something must be done to bring down the high cost of drugs. However, we opposed their proposals for the following reasons.

First, it appears to violate the prohibition against maximum price-fixing by health care providers which the Supreme Court reaffirmed in 1982 in *Arizona* v. *Maricopa County Medical Society.* Second, it is not likely to lower drug prices for most consumers. Third, an agreement on price limits could spill over into other mar-

kets and enable PMA members to resist the demands of large purchasers for deep discounts. In short, it is simply not worth the risk.

My view is that if the industry is serious about lowering drug prices, they can do so without violating the antitrust laws. There is no reason that each individual drug company cannot make a public commitment to limit price increases and then stick to it. Frankly, I would urge them to do so without further delay.

Our antitrust laws have been a bulwark against anticompetitive conduct for over 100 years. I recognize that some of the groups here today believe that those laws treat them unfairly. However, it has been my experience that the antitrust loopholes sought by businesses are rarely in the best interests of consumers.

Senator Hatch, we are very happy you are with us here this morning.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM THE STATE OF UTAH

Senator HATCH. Well, thank you, Mr. Chairman. I am happy to be with you and I appreciate your holding these hearings. I am personally glad that this hearing is taking place today because we all know that health care reform is a critical issue facing our Nation and facing the U.S. Senate. Of course, we will be considering a number of proposals, including the Clinton administration plan which will be submitted in the next 6 weeks or so.

Most of these comprehensive health care reform plans will restructure the health care delivery system. The restructuring will result in health care market consolidation. The prospect of such consolidation raises questions about the application of antitrust law, and I believe it is time for us to begin thinking about the antitrust laws and policies that may need to be changed if health care reform is ever to be successful.

We should begin by identifying potential antitrust risks that the health care delivery and insurance systems would face if the proposed organizational changes to the way we purchase and deliver health care were instituted without special legislative protection.

I ask the witnesses to consider the purpose of this hearing, the relationship between antitrust policy and health care reform. I anticipate that in this discussion the witnesses will tell us what they believe is good about today's antitrust enforcement approach as well as what problems exist.

I know that in the State of Utah the taxpayers and the medical community have spent millions and millions of dollars providing documents, explaining actions, and defending against Federal antitrust investigations. Dollars that should have been spent on preventing and treating disease have been spent on lawyers. This seems ludicrous at a time when all Americans are focused on trying to reform the health care system and on preventing inappropriate allocation of scarce resources. We are very concerned about this situation because it seems to me that almost all of those issues could have been resolved had we just gotten together the State, Federal, and other parties to agree on what really is the best way to approach the problems that were in existence at the time, and I don't see why we can't do that even now.

Given this example of current application of antitrust laws, we must not fail to consider the future effect of antitrust law during our discussion of comprehensive health care reform. We must address the unnecessary causes of overly costly services or products. Most Americans, for example, understand the extra costs that defensive medicine and the threat of malpractice impose on health care. However, the hidden costs of other systemic problems such as those posed by unrealistic or inappropriate antitrust policy are less obvious.

Consumers may realize when their local community has more hospitals than seem necessary, operating with empty beds or when the locality has more than one expensive health care service center, such as a trauma center or medivac helicopter service. They realize that one service would work better and at less cost. Indeed, the many proposals now under discussion for "managed competition"—and there are many definitions for that—are a recognition of the need for greater efficiency in the amount, allocation, and use of resources devoted to health care.

The American health care system is unique in several ways. First, it is highly regulated. Second, most Americans have some sort of health insurance, leaving them indifferent to the price of health care except at the margin. And, third, accompanying this indifference to price is a nearly limitless demand for services. Many argue that the health care market has become increasingly dysfunctional over time and that its many unique features interfere with the supply and demand functions associated with truly free markets.

In order to increase access and maintain quality, some health care providers have sought to increase efficiency by collaborating in order to reduce overcapacity and to eliminate duplication of services or equipment. Others wish to set up regional networks of services. Yet, I have heard serious complaints about our own Government discouraging such efforts. While President Bush talked about coordinated care, his own Justice Department was doing everything to stop coordinated care. The activities of our Department of Justice and Federal Trade Commission have been said to have a very chilling effect on efforts to achieve efficiency.

For example, providers of health care are afraid that if they even meet once to discuss more efficient arrangements for health care delivery, they could become the target of an antitrust investigation or enforcement proceeding. Although such charges do not always stick, they always have to be defended at a very substantial cost and always have uncertain outcomes.

Over the last 50 years, the Government has exercised an increasingly greater role in all aspects of the health care system from fundamental biomedical research to access to disease prevention and treatment. For example, the Federal Government stimulated and paid for a substantial portion of our current excess capacity of hospital beds. Almost half of all U.S. health care costs are paid for by the Federal Government.

Today, the Government is the dominant force in U.S. health care, both in setting standards for services and products and in paying for them. The fact that the Federal Government plays such an overwhelming role in health care is another reason that health care

may not fit easily into the free market economic set of models typically used in antitrust enforcement in other areas.

Managed competition is one reform model receiving widespread attention, as we all know. It is likely that Ms. Clinton's task force will come up with some form of "managed competition." It involves a policy that encourages health care market consolidation through the establishment of managed care networks called Accountable Health Plans, or AHP's. The AHP's would have some of the same characteristics as health care maintenance organizations of today—a combination of provider networks with an insurance function. Managed competition also may create entities with substantial purchasing power through the pooling of individuals and employees of small businesses into very large groups called Health Plan Purchasing Cooperatives, or HPPC's.

I will ask the witnesses to consider what additional risks to antitrust enforcement they think these players—that is, the AHP's and the HPPC's, and drug and device and other technology manufacturers—might be exposed to if such reforms were enacted.

Now, we cannot craft the necessary changes to the antitrust laws until we have answered certain policy questions, questions such as who will own and govern the large purchasing groups and what, if any, statutory restraints will be placed on their ability to exclude managed care networks. Should we allow the large purchasing groups to develop monopsony power in an area? What would be the result of that? What difficulties would the health care networks face in terms of their development? How do we ensure that provider networks do not charge monopolistic prices in an area in which they are the sole provider?

Managing competition through the creation of very large group purchasers and managed care networks is described as having the potential of increasing "true competition." We need to be able to determine the net effect of combining a monopoly provider of services with a monopsonistic purchaser in a given market area.

Many proposals contain the concept of provider network development. Many proposals result in the pooling of purchasing power. The fundamental question is, without statutory protection, will our antitrust policy allow health care reform to flourish or will it cause health care reform to be stymied and wither before it has a real chance to work.

I would like to mention in closing that, in my view, the most effective health care reform will be that which encourages the maximum reliance on individual initiative and helps to develop an effectively functioning market for American health care. Thus, I would urge that we consider reforms to antitrust that would actually strengthen our competitive system, and I am not bound down by past ideas that there is only one way to do this. I think we have got to look at it and look at it carefully. It is going to play a very significant role as to whether or not we solve health care problems in this society, and we can't just say, well, the present law is the only way to go.

It seems to me we have got to have open minds, listen to the leaders in this area, make sure that we give every shot to do what is in the best interests of all concerned, and I think we must be

rather innovative and creative in our approach to these antitrust problems.

Thank you, Mr. Chairman. I know this was a little bit of a lengthy statement, but I think I needed to make it.

Senator METZENBAUM. Well, we are very pleased that you did and we are very happy to have you participate in the hearing.

Senator Thurmond?

OPENING STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Senator THURMOND. Thank you, Mr. Chairman. The focus of the hearing this morning is on the health care field, which is of great importance to the well-being of every person in our Nation. A solid health care system is critical to the ongoing strength of our citizens and our Republic. In addition, health care is a field in which America remains a world leader. People from around the globe come to the United States in order to receive the best possible health care. Our country exports many billions of dollars worth of pharmaceuticals and other health care products and services.

However, there is great concern that health care is too expensive and not as efficient as it should be. As a country, we are spending a larger and larger portion of our total output on medical services. We have now reached a point where almost one out of every seven dollars of our Nation's output goes for medical care.

Significant efforts are under way to reform health care. The goal of such reform should be to increase efficiency and hold down costs without sacrificing the high quality of care which the people of our Nation expect and deserve. While proposals for reform are currently being formulated, it is appropriate for this subcommittee to be a participant in the important debate on health care reform.

What is the role for the antitrust laws and antitrust enforcement in the health care field? Antitrust enforcement has been important at times in eliminating restrictions which prevented competition in the health care field. There should be no exceptions made in the antitrust laws without compelling reasons. Yet, as efforts are made to reform health care, certain changes may be necessary in the antitrust laws or enforcement in order to permit new efficiencies in the health care field to be achieved. I look forward to receiving the testimony to be given today and believe it will be helpful in developing adequate health care reform.

In conclusion, Mr. Chairman, I want to welcome Senator Cohen, Chairman Steiger, and the other witnesses and to thank each of them for their time in appearing before the subcommittee this morning.

Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much, Senator Thurmond. We are very pleased that you are participating with us this morning.

Senator Cohen, we are very happy to hear from you, and why don't you and Chairman Steiger both come to the table at the same time? I think the procedure we will follow is we will hear you, Senator Cohen, and then we will have some questions for you. You may have some other obligations to get to.

OPENING STATEMENT OF HON. WILLIAM S. COHEN, A U.S. SENATOR FROM THE STATE OF MAINE

Senator COHEN. Thank you very much, Mr. Chairman. I appreciate the opportunity to testify at this morning's hearing.

As has been pointed out by everyone here on the panel, the American health care system is the most innovative and technologically advanced in the world, but it is also the most expensive. The total health care costs which were earlier expected to top the $1 trillion mark by the turn of the century now appear likely to reach that level as early as next year, and the Institute of Medicine estimates that the use of new technologies, and the overuse of existing ones, account for as much as 50 percent of our annual increase in health care costs.

America's health care providers are engaged, in my opinion, in what amounts to a "medical arms race." Every hospital wants to have the latest in high-tech machinery and hardware, and then make sure that the equipment is in constant use to pay for it. I think it is time to call a halt to the high-tech arms race and encourage hospitals, if I can use this phrase which I used in other contexts some years ago, to "build down" their medical arsenals. We simply cannot afford a system which promises a CAT scan in every clinic and an MRI in every community hospital.

Hospitals should be encouraged to collaborate and develop more rational health care systems based on the needs of the community rather than the profit motive of the provider. These "community partnerships" have the potential not only to reduce health care costs by eliminating unnecessary duplication, but also to enable smaller hospitals to share expensive equipment that couldn't be supported by one hospital alone, thus increasing access to services in rural areas.

However, I am concerned that our Federal antitrust laws and enforcement policies may be unduly hindering these agreements. I understand that the problem is often simply a misunderstanding or misinterpretation of the antitrust law and that some cooperative activities are, in fact, permissible. However, I believe there are significant barriers, both real and perceived, to collaborative activities that would clearly be beneficial to both consumers and providers of health care.

To give you an example, in my home State the Maine Hospital Association has embarked on a "Future Directions" project to encourage hospitals throughout the State to work together to share services and costs. To support this process the State has adopted legislation establishing a process for the review and approval of cooperative projects that has removed some of the antitrust barriers that have traditionally discouraged these endeavors.

There has been a subsequent explosion in cooperation agreements across the State, and I will give you some examples. Last month, a new $1.25 million Coastal Cancer Treatment Center opened in Bath, ME. This new facility was developed by a consortium of six midcoast hospitals. It will serve patients from Freeport to Camden, ME. Previously, cancer patients living along the coast had to travel many miles to Portland or Augusta for their treatments.

Twenty hospitals in northern and southern Maine now refer patients to a linear accelerator. This is a cancer treatment device that produces high-energy x rays to treat tumors with minimal damage to surrounding tissue. This is at the Eastern Maine Medical Center in Bangor. Cancer screening and other treatment needs are handled by the local physician and hospital, but the expensive high-tech activity is handled by the regional referral center, making the system much more efficient.

The Aroostook Medical Center—that is up at the top of our State in Presque Isle—and the Cary Medical Center in Caribou, a nearby town, have recently announced their intention to merge, and the decision to consolidate these two facilities makes ultimate sense, particularly in light of the closing of Loring Air Force Base and the uncertain economic climate in the area.

I doubt this decision would have been made without the antitrust immunity now afforded by the new State law, particularly if Aroostook County has been following the saga of the merger of the Ukiah Valley Medical Center with the Ukiah General Hospital in rural Mendocino County, CA.

I understand you are going to hear a great deal about Ukiah Valley's experience later, but in essence the hospital had bounced back and forth through the various levels of the FTC for more than 4 years, spending in the process an estimated $1 million that otherwise could have been spent providing care. The merger did proceed as planned and has clearly demonstrated cost savings, increased efficiency, and significant improvement in the quality of health care available in the area, but still the hospital remains involved in an antitrust dispute.

Now, I have introduced two bills to encourage collaborative arrangements by providing a measure of protection against these antitrust concerns. The Access to Affordable Health Care Act includes a "waiver" provision under which hospitals could apply for an antitrust exemption for cooperative efforts that are likely to reduce costs, increase access, and improve quality of care.

I have also introduced a separate bill that authorizes demonstration projects to determine the extent to which cooperative agreements between hospitals can be successful in meeting these objectives. The formation of provider networks is a key component of the managed competition model for health care reform that is being advocated by President Clinton, and I believe these collaborative arrangements are going to be essential if this approach is going to work, particularly, as Senator Hatch has talked about, in rural areas. I would urge the subcommittee to consider these proposals as it develops recommendations for further action.

Finally, just a brief comment, Mr. Chairman, about the pharmaceutical industry's recent request to the Department of Justice. The Pharmaceutical Manufacturers Association is under increasing pressure from the Congress and the administration to lower prescription drug prices. It has sent a letter to the Justice Department requesting a "business review letter" allowing them to voluntarily restrain price increases for pharmaceuticals.

While I am pleased that the drug industry is finally seeing the need to curb high drug prices, I must admit I remain skeptical of the request. Drug companies have always had the ability to hold

down their prices voluntarily and they can control their own prices now by behaving responsibly. I don't believe that granting this request is going to somehow magically instill the sense of compassion for the consumers' pocketbooks which has been so sadly lacking on the part of the major drug manufacturers.

Last year, several major drug manufacturers independently agreed to keep their increases at the rate of inflation, but the end result was not a lower price for the consumers. A recent staff report by the Senate Special Committee on Aging found that despite the pledges made by major pharmaceutical companies to stabilize their prices, 19 of the top 31 drug manufacturers increased prices at more than twice the general rate of inflation for 1992.

I think pharmaceutical prices have risen too fast, too often, and too arbitrarily, and before we allow the companies to establish an industry position on drug prices, I think we have to be confident that the consumers and competition and the market would benefit.

Again, I thank the chairman and the committee for their indulgence in my testimony this morning.

Senator METZENBAUM. Thank you, Senator Cohen. I am particularly pleased about your comments concerning the PMA activities and their efforts to avoid the antitrust laws by agreeing to hold down prices and asking for an exemption from the Antitrust Division.

In that connection, as I previously mentioned, Senator Pryor and I sent a letter to Janet Reno on this very subject. Without objection, that letter, in its entirety, will be included in the record.

[The letter referred to follows:]

U.S. SENATE,
Washington, DC, March 18, 1993.

Hon. JANET RENO,
Attorney General, U.S. Department of Justice,
Washington, DC.

DEAR GENERAL RENO: We are writing to follow up on a concern that Senator Metzenbaum raised with you during your confirmation hearing. The Pharmaceutical Manufacturers Association ("PMA") has requested a business review letter from the Department of Justice that would exempt its members from antitrust prosecution for certain price agreements. Specifically, the PMA has requested immunity to "set out a pricing policy by which member companies, acting individually and unilaterally, would agree to be bound." This policy would commit each PMA member to "limit its price increase, if any, on the entire line of its prescription drug products in any calendar year to an amount not to exceed the increase in the CPI." New drugs would not immediately be covered by this agreement.

Although we applaud the PMA for acknowledging publicly that action must be taken to bring down high drug prices, we do not believe that you should approve their request for special antitrust protection. First, PMA's request appears to violate established antitrust law that prohibits maximum price fixing. Second, PMA's proposal is not likely to be effective in lowering drug prices, and could increase prices for some consumers and many health care institutions. Finally, allowing PMA member companies to agree on price limits, for any purpose, could spill over into other markets, and thereby enable PMA member companies to resist the demands of large purchasers, such as Health Maintenance Organizations ("HMO's"), which have successfully negotiated price discounts. Allow us to explain each of these points.

The agreement for which PMA has requested immunity is similar in many crucial respects to the price fixing agreement condemned by the Supreme Court in *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332 (1982). In *Maricopa*, a group of physicians had agreed to maximum limits on the fees that they charged to patients insured under approved health plans. The physicians argued that their agreement was procompetitive, and hence not an antitrust violation, because it would allow them to "impose meaningful limit[s] on their charges," and to "provide consumers

of health care with a uniquely desirable form of insurance coverage that could not otherwise exist."

The Court rejected the justifications proffered by the physicians reasoning that "[e]ven if a fee schedule is desirable, it is not necessary that the doctors do the price fixing." The Court's central concern was that an agreement on maximum prices, even one undertaken for ostensibly procompetitive reasons, can become a "scheme [that] tends to acquire all the attributes of an arrangement fixing minimum prices."

Much like the doctors in *Maricopa,* the PMA argues that its price agreement should be immune from prosecution because it is procompetitive in that consumers would benefit from a limit on drug prices. The fact is that PMA's proposal does not assure a limit on drug prices for any purchaser. However, even if it did, there are more effective and less anticompetitive means that PMA can use to reach that goal. At its recent Board Meeting, the PMA itself proposed one such alternative:

> [T]he Administration [could] seek individual company commitments to restrain price increases. Ten leading manufacturers * * * already have independently and voluntarily made public commitments to restrain their price increases to the Consumer Price Index. The PMA Board has urged the Administration to seek such commitments from other companies.

The second important reason for the Department to reject the PMA's proposal is that it could result in some purchasers paying higher, not lower, prices for prescription drugs. In its letter, the PMA states that the "effect" of the agreement for which it seeks immunity would be to permit drug makers to "limit the aggregate price increase for prescription drugs to amounts not exceeding the CPI." In other words, under their agreement, the PMA members would be free to raise drug prices in one market to recoup price reductions in another market. Consequently, consumers who do not obtain their drugs through an HMO or other larger purchaser, which can negotiate discounts from the drug makers, could find themselves paying higher prices.

Finally, the PMA agreement on price limits could spill over into other markets, and thereby threaten the recent increase in aggressive price competition in that industry. On March 11, the *Wall Street Journal* reported that "[f]or the first time in years, competition among drug makers is prompting some companies to try an aggressive marketing approach: lowering prices." Ciba-Geigy was reported to have slashed the cost of its new heart drug, Lotensin, by up to 50 percent below its competitors' prices in order to win HMO sales.

Competitive pressures have spurred cost-conscious private purchasers, such as hospitals, HMO's and mail-order pharmacies, to demand and to get deep discounts on drug prices. Under the PMA's proposal, there is a real danger that the maximum price increase that PMA members agree upon could become the only price at which a large purchaser could buy a drug. This would have the effect of increasing drug prices for institutions and undercutting efforts to promote price competition among providers, including drug makers.

We hope that you will agree that the PMA's proposal is simply not a viable solution to the problem of high drug prices and reject its request for an exemption from antitrust prosecution.

Sincerely,

(Signed) Howard M. Metzenbaum

(Typed) HOWARD M. METZENBAUM,
Chairman, Subcommittee on Antitrust, Monopolies and Business Rights.

(Signed) David Pryor

(Typed) DAVID PRYOR,
Chairman, Special Committee on Aging.

Senator METZENBAUM. Senator, I believe the hospital technology sharing demonstration projects you have proposed could be very useful. It could actually provide needed data on how hospital-sharing arrangements affect costs, access, and quality. However, I am not sure they need antitrust immunity. Both the Antitrust Division and the Federal Trade Commission have stated publicly that such technology-sharing arrangements rarely raise antitrust concerns. Neither enforcement agency has challenged a single joint venture of that type. Moreover, a technology-sharing arrangement sup-

ported by the Department of Health and Human Services would be even less likely to be challenged.

Now, I am aware of the Ukiah Hospital case. It has been a long time since I practiced law, but I had the feeling as I looked at some of the files in that case that more time has been spent on the jurisdictional questions and on technical aspects of the case than really should have been spent and, as a consequence, ran up the legal bills to a very inordinate amount.

Having said that, I sort of question why the case ever had to go as far as it did because the Ukiah case—I think there is some merit to be made for their position, and I think they got involved in technical aspects rather than getting into the substance of it.

My question to you is, Wouldn't it be possible to go forward with these demonstration projects without immunizing them from the antitrust laws?

Senator COHEN. Well, Mr. Chairman, I think that is entirely possible, and I respect what you have suggested about the ability of hospitals to share this technology without necessarily running afoul of the antitrust laws. It may be simply a perception problem, but I must tell you I have spent considerable time talking with hospital administrators and they have all expressed fear, whether legitimate or not, about sharing technology with other hospitals.

As a result of the State of Maine taking action, now virtually there is immunity from Federal prosecution. Since the State, in fact, has passed legislation which would authorize these types of agreements, there has literally been an explosion, as I said before in my statement. There has been a proliferation of these arrangements now that they no longer fear that they will be sued.

Perhaps individual States can do the same thing and follow Maine's lead or perhaps the legislation that I propose, by creating ten 5-year demonstration programs, would be very limited in terms of providing the exemption from the antitrust laws, and it might very well serve as a model for the country.

So I think to the extent that we authorize the projects, if there is no need for a change in legislation, if the FTC and the Justice Department feel that there is no problem as long as Congress is authorizing demonstration projects, then I don't have a problem with that.

Senator METZENBAUM. I think that the problem is not too serious. Maybe it can be worked out. Maybe we can be helpful in that respect.

Senator Hatch?

Senator HATCH. I just wanted to thank you for your leadership in this area, and I appreciate your statement here today. I am very happy to have you on this committee.

Senator COHEN. Thank you very much. Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much, Senator Cohen.

[Senator Cohen submitted the following:]

PREPARED STATEMENT OF THE MAINE HOSPITAL ASSOCIATION

The Maine Hospital Association has sponsored a project to develop integrated networks of providers and others on a collaborative basis in order to more efficiently deliver needed health care services on a cost effective basis whenever collaboration makes sense to better deliver health care services. This project is over two years

old and to this point in time has achieved remarkable consensus among hospitals in Maine to reform the health care delivery system through provider networks.

As part of this project, it was also necessary to identify barriers to forming networks. One of the more immediate barriers is the antitrust laws, since provider networks frequently may involve collaboration among providers that may otherwise be deemed "competitors" of each other.

Great uncertainty over the legality of networks constrained the pace at which networks would be formed, especially in a largely rural state such as Maine.

To address this barrier, the Maine Hospital Association sponsored legislation, enacted by the Maine Legislature last year, providing for the replacement of the antitrust laws' traditional after-the-fact imposition of penalties with before-the-fact approval by regulatory authorities in Maine.

This act, known as the Maine Hospital Cooperation Act, is based on the following principles:

1. Discussion among hospitals about various ways to cooperate to improve access, quality and affordability should occur, and should not be chilled by the specter of antitrust liability and prosecution;

2. Cooperative arrangements should be evaluated on their expected total contribution to health care quality, access, cost control and consumer welfare and not merely in terms of their pro-competitive and anti-competitive effects;

3. Hospitals who cooperate and receive regulatory approval for their agreements should be able to do so with relative assurance that their conduct is lawful (i.e. without fear that their conduct will be deemed to violate the antitrust laws by either a government antitrust regulator or a court in a private damage action);

4. If a cooperation agreement is in the public interest (as more broadly defined) the hospitals should be able to demonstrate it beforehand to the satisfaction of disinterested public officials as the "price" for obtaining an exception to the antitrust law.

The mechanics of the Act are straightforward:

1. Discussions about cooperation are lawful, provided that the results of the discussions (a cooperative agreement) are submitted to the State for approval.

2. Agreements are reviewed by both the primary health care facility regulatory agency and the State antitrust enforcement agency.

3. The criteria include traditional antitrust concerns with competitive impact, but are expressly broadened to include quality and access.

4. The burden is on the hospitals to show that the benefits of the arrangements in quality, access, or cost containment outweigh the harm from any diminishment of competition.

Since the passage of the Act, there are ongoing active discussions between hospitals dealing with such things as capacity reductions through complementary service allocations, eliminating services to certain hospitals and consolidating laboratory testing in urban areas with multiple hospitals. In addition, in almost every community where there is more than one hospital, discussions are underway to address ways to reduce health care costs through cooperative activities by eliminating duplicative services, downsizing, and exploring various ways hospitals can reorganize to provide services more efficiently.

More importantly, the passage of the Act has removed the veil of uncertainty regarding antitrust exposure at least for hospitals in Maine, and they are now in discussions through the State regarding the formation of networks.

Senator METZENBAUM. Ms. Steiger, we are very happy to have you with us here this morning. I think you are aware of the subcommittee's 5-minute rule for witnesses. We have a lot of them this morning, but we are delighted that you are with us.

STATEMENT OF HON. JANET D. STEIGER, CHAIRPERSON, FEDERAL TRADE COMMISSION, ACCOMPANIED BY MARY LOU STEPTOE, ACTING DIRECTOR, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION

Ms. STEIGER. Thank you, sir. We are very pleased to be here and to present the testimony of the Federal Trade Commission on the relationship between antitrust enforcement and health care reform. With me today at the table is Mary Lou Steptoe, the acting director——

Senator METZENBAUM. Could you bring the mike a little closer and slow down just a little bit?

Ms. STEIGER. With me today at the table is Mary Lou Steptoe, who is the acting director of our Bureau of Competition. With your permission, sir, I will submit the Commission's authorized written testimony for the record—it is lengthy—and present a short oral version, with the usual disclaimer that the oral version and my responses to questions will be my views, not necessarily those of the Commission or other commissioners.

Health reform, as we have already heard this morning, is a high-priority topic, and I do not expect to discuss any particular reform proposal. But, rather, as chairman of the agency that has long defended competition in health care, I do want to discuss the role of competition in health care reform and I make two principal points.

First, sound antitrust enforcement by the Commission has played a key part in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. The Commission has challenged rules that prohibited physician affiliation with such plans and organized boycotts by some health care providers against newly developing health care arrangements.

We have sought to prevent transactions that would likely lessen competition and have issued orders to prevent price-fixing, tying, and other anticompetitive practices. We have also intervened to prevent some providers from banding together specifically to frustrate cost containment measures by third party payers.

Second, so long as our health care system leaves a role for competition, antitrust vigilance will remain important. I will not suggest that any particular antitrust exemption would doom any particular health care plan. However, our experience convinces us that proposals for broad statutory antitrust exemptions now being advocated by some provider groups, physicians, hospitals, pharmaceutical companies, and others in the health care industry could frustrate the drive to contain rising health care costs.

The Commission does not favor one type of health care delivery system over any other, nor have we created any of these plans. But we believe that it is important to keep markets competitive so that consumers can choose. Our antitrust enforcement effort has been directed to ensure that anticompetitive behavior does not impede or block the development of health care alternatives that consumers might elect to use.

Early forerunners of today's health care plans did meet with opposition. Some physicians affiliated with these plans risked charges of unethical conduct, expulsion from local medical societies, and loss of hospital privileges. The 1943 Supreme Court decision that

you referenced, Mr. Chairman, upheld a criminal antitrust conviction of the AMA and others for conspiring to obstruct an early HMO.

In 1975, the Commission issued an administrative complaint challenging the AMA's ethical standards, alleging that the ethical restrictions prohibited physicians from providing services to patients under a salaried contract with a lay hospital or HMO. These standards prohibited, among other things, accepting inadequate compensation for medical services measured against the usual fees in the community, and in 1979 the Commission held that all of those restraints violated the antitrust laws.

But even after the AMA freed physicians to affiliate with health care plans, the plans often continued to face boycotts by providers. The Commission has taken action to remedy such conduct as denying participation in Blue Shield programs to physicians working for an HMO, obstructing hospital privileges for HMO physicians, and boycotting a hospital that was planning to open an HMO facility.

We have also acted against provider efforts that sought to frustrate the operation of cost containment programs, most recently through consent orders with associations of pharmacies and their members who allegedly organized boycotts of third-party payer cost containment efforts.

One claim we hear with increasing frequency is that antitrust has no useful role to play with respect to hospital mergers and joint ventures. Let me assure that sound antitrust enforcement does not hinder such transactions when they are procompetitive, and the vast majority of hospital mergers and joint ventures do not endanger competition. Some, however, are anticompetitive and we seek to ensure, where possible, that health care buyers have a sufficient selection of competing providers to try to obtain high-quality and low-cost health care services, and buyers of these services confirm the importance of choice in our investigations of proposed transactions. A recent article also referenced by you in your opening statement, Mr. Chairman, in Modern Health Care examined the record and dismissed the claim that antitrust enforcement inhibited hospital cooperative joint ventures.

I will leave the rest of my testimony, sir. I notice my time is up. I will note that there are matters before the Commission in administrative adjudication that I will not be able to address, but with that caveat, let me see if I can answer your questions.

Senator METZENBAUM. Thank you very much for a very good statement. The FTC has been criticized by the hospital industry for chilling procompetitive mergers and joint ventures. One of the most pervasive criticisms has been that the merger guidelines under which the FTC operates don't take the cost-cutting efficiencies of a merger into account.

I understand that, as a practical matter, the Commission gives a great deal of weight to efficiencies, particularly if they are likely to be passed on to purchasers in the form of price reductions. Can you explain to us how the Commission views the efficiencies created by a merger and what weight you give to them in deciding whether to challenge a hospital merger?

Ms. STEIGER. First, I would like to state again, Mr. Chairman, that the challenge made to a hospital merger is a rare event. We

have challenged only seven; two I mentioned are in administrative litigation. Most hospital mergers are procompetitive, as the record shows.

We believe that the 1992 joint guidelines of the Department of Justice and the Federal Trade Commission are indeed flexible enough to take into account the particular characteristics of this industry, as they are able to account for particular characteristics in other industries.

We evaluate many more factors than mere concentration, sir. We do evaluate entry conditions, we do evaluate the market itself to see whether consumers will be adversely affected by the proposed merger. And, yes, indeed, we do examine claimed efficiencies brought to us by the parties particularly to see if they will offset what may appear to be anticompetitive problems in that marketplace. We take efficiency analysis very seriously.

But as the court noticed in the HCA case, these must be merger-specific and they should be able to be demonstratively passed on to consumers, but they are very high on our list of considerations. I would note we have never challenged to date a joint venture between hospitals. This is a clear recognition that such joint ventures can be procompetitive and efficiency-enhancing, and we have, even in consent agreements taken involving hospital mergers, specifically allowed for joint ventures to go forward. I hope that is responsive, Mr. Chairman.

Senator METZENBAUM. Thank you very much. Now, the FTC has been criticized for challenging the merger of two small rural hospitals in California. Frankly, I myself question whether the FTC should have brought the case or whether it should be pursuing it now. It was dismissed by an administrative law judge last December. I was surprised that it was appealed to the full Commission.

Because that case is on appeal to the Commission, I know that you cannot comment on it. However, speaking more generally, is the Commission able to consider the special circumstances of rural hospitals in deciding whether to challenge a merger, and what kind of special considerations are rural hospitals likely to get from the Commission?

Ms. STEIGER. I repeat again that we do believe that the merger guidelines that we use as a tool for analysis are flexible to take into account even so-called specific features of a market. We are aware that there are concerns expressed, and there have been in the literature, about the minimum scale required for efficient operations. We are aware of that literature. We take such concerns into account in our analysis.

The vast majority of mergers we have further looked into, or the few that we have challenged, involve entities of substantially greater size and population than those minimum efficient concerns that have been expressed. I will note that just as a general point. Here, again, it is well to reemphasize that we would take efficiencies very seriously and that they would be, no doubt, presented in such a case hypothetically as a reason to forego a challenge, and I think the antitrust laws are indeed up to that, again noting that I can't speak with reference to the particular matter that is of interest to the committee today.

Senator METZENBAUM. Now, the AHA argues that hospital markets are not like other markets that respond to competition with lower prices and better quality. AHA's report on collaboration states that "Studies cast doubt on the presumption that in concentrated hospital markets increased market competition by itself will lead to higher prices and/or costs to purchasers of health care services."

Has the Commission found evidence that hospital markets do not respond to competition and, in addition, can you give me an example of a hospital market that has benefited from competition?

Ms. STEIGER. We are aware of the literature that you have just referenced. There is literature also on the other side that indicates that competition indeed does provide a cost containment mechanism. We have heard this argument from customers. We pay very close attention to customers. In this market, they would most likely be very large buyers of the services of the health care community. They have expressed concern about a lack of competition as a frustration of cost containment, and we have also heard from the hospitals' own documents that competition is regarded as a matter that can decrease the cost spiral. So we think there is evidence on the side that we are presenting to you this morning.

Senator METZENBAUM. Now, I understand the Commission has actually not challenged a single joint venture or collaborative arrangement among hospitals. Even so, an AHA white paper charged that

> If two or more hospitals wished to reduce existing duplication of services or equipment by joint venturing services, the antitrust risks may be substantial, at least in communities with few hospitals.

I have a little difficulty in understanding that since you have not challenged any mergers. Do you agree with the AHA statement that joint ventures and other sharing arrangements pose "substantial antitrust risks?"

Ms. STEIGER. The record would not bear out that contention. As we have said and you have just noted again, we have never challenged a joint venture in the hospital area. I would suggest that Senator Cohen's statement that there is a perception problem here could very well be true.

To the extent that we could do better in stating the positions on potential agreements of this nature, joint ventures, we should try to do so, but I would note, Mr. Chairman, that officials of the Commission have spoken over and over again and at great length to various aspects of these concerns and we will continue to do so.

We also stand ready, as I know does the Department of Justice, to offer opinion and assistance from our expert staff on questions of this nature prior to the completion of some sort of an agreement, and we are always read to do that. We do it routinely and we have offered scores of staff advisory opinions. So we will continue to attempt to alleviate this perception problem, but I don't think the record bears out the reality.

Senator METZENBAUM. The Department of Justice has launched a pilot program to expedite business review letters to businesses which have questions about how the antitrust laws will apply to a specific deal. Would it be helpful to hospitals and other health care providers if the FTC were to launch a similar program?

Ms. STEIGER. We do not have that exact program of the business review letter. However, as mentioned, our staff is as far away as the telephone or a fax from anyone seeking at any time advice in the antitrust field based upon our experience and expertise, and we continue to hold out that offer to any interested group or individual.

Senator METZENBAUM. It appears to me that joint ventures and sharing arrangements in many instances are going to be beneficial because they can eliminate waste and duplication. However, we will hear testimony later from a witness, Mr. Vernon Rothschild, which suggests that some hospital joint ventures can shut out legitimate competitors and lead to higher prices or lower-quality services.

The question Mr. Rothschild's testimony raises is whether hospital joint ventures could contribute to the problem of spiraling health care costs if they make it impossible for competitors to enter or to stay in the market. How does the Commission evaluate joint ventures that might block other competitors from the market, and under what circumstances would such a joint venture be challenged?

Ms. STEIGER. I can't speak to the specific question raised by the witness this morning, but as a general point let me say that if a firm with market power is using exclusionary practices to eliminate competition, they might be accused of monopolization. On the other hand, it is important to remember that the integration of a firm in one line of business into related fields may be efficient.

What I am saying is that this is a case-by-case and probably a very factually specific analysis, but we would certainly be capable of making that analysis and would be interested in situations where such a problem is charged, as a general rule.

Senator METZENBAUM. My last question: The AMA has petitioned both the FTC and the Congress for what it has characterized as a clarification of the antitrust laws. I would like to have an opportunity to comment on the AMA's petition before your Commission acts. In fact, I would welcome the opportunity to appear before the Commission and discuss my views on the AMA's petition, if that is appropriate.

The antitrust legislation that the AMA has proposed would allow groups of doctors who have no special affiliation to one another to bargain collectively when they deal with a large purchaser such as an HMO or an insurance company. It is my understanding that doctors are permitted to bargain collectively if they do so under the auspices of a preferred provider organization or a multispecialty practice group.

Can you explain to us how the FTC evaluates collective activity by doctors?

Ms. STEIGER. Yes; first, we would, of course, be delighted to receive written comment on this proposal or any other. Collaborative activity—I would think your analysis begins with the *Maricopa* Supreme Court decision which takes as one of the indicia for limiting concern about antitrust violations the integration of risk, particularly capital and financial risk. This is a useful benchmark to begin to look to as we consider collaborative activities.

Again, each of these situations will be highly fact-specific and deserves the kind of analysis that fact-specific cases always demand. Again, I think the antitrust laws and the Antitrust Division and the FTC are perfectly capable of offering advice in this area, as well as making reasoned decisions about enforcement.

I would give a status update on one matter before us by the AMA regarding a proposed peer fee review plan. I understand that final discussions as far as information gathering—staff sought further information from the AMA on this particular proposal and its structure, and further conversations took place in February. I expect that analysis to be forwarded to the Commission and I think the Commission will respond expeditiously to this particular part of the AMA's interest, which is peer fee review programs.

Senator METZENBAUM. Thank you very much.

Senator Hatch?

Senator HATCH. Thank you. Welcome. We are happy to have you here, Ms. Steiger. One of the hospital industry arguments is that the FTC merger enforcement efforts have a random quality about them.

Senator METZENBAUM. Senator Hatch, I am not sure they can hear you out there.

Senator HATCH. Can you hear me?

Ms. STEIGER. I could, sir, but I don't know if they can.

Senator HATCH. Well, I will try and talk a little louder.

Their argument is that hospitals cannot distinguish between mergers you would challenge, or at least investigate, and those you don't. Now, certainly, you agree that many of the mergers you don't challenge or even investigate through a Hart-Scott second request are above the 1,800 market concentration index which the merger guidelines say is presumptively illegal, is that correct?

Ms. STEIGER. I would certainly say that concentration is not the be-all and the end-all of our investigations, and the 1992 merger guidelines make that very clear. We look well beyond it into the market structure, as I said, into entry barriers, as well as into claimed efficiencies. So it is a piece, but not the beginning and the end of our analysis.

Senator HATCH. OK, but any combination in markets with six or fewer hospitals creates a market concentration index above 1,800.

Ms. STEIGER. That is probably true, sir.

Senator HATCH. And from that, almost all mergers in all but large cities would be above the market concentration standard for presumptive illegality. Can you articulate the factors which you use in deciding not to challenge a merger that is above the market standard for presumptive illegality?

Ms. STEIGER. First of all, I think the limited number of challenges would indicate that we obviously go well beyond in our analysis simply the concentration numbers. It is true that in the many mergers we do not challenge, the Commission does not make public statement as to why they did not challenge the merger. That is because most of the material upon which we base our decision is nonpublic, but I can understand if someone says, we don't know why you didn't challenge *x*. I think probably antitrust counsel would be well aware, looking at the factual pattern, of why we did not.

Nonetheless, we do try to explain as fully as possible when we do challenge a merger why we have done so. In fact, we must so explain, and we continue to attempt to bring to the public and the interested parties general statements as to what raises antitrust concern and what does not.

I would make specific reference to the importance of market definition in the hospital area. We look very closely at such figures as what doctors have hospital privileges where, what is the inflow and the outflow of patients, because the geographic market is a very important point to be determined in hospital mergers, as a general rule.

Senator HATCH. Could you submit a document for the committee to include in the record of this hearing that will describe with specificity the type and the scope of efficiencies you would view as sufficient in order for you not to challenge a merger in a market where, after the merger, there would be, one, no competing hospital; two, only one other competing hospital; three, only two other competing hospitals; four, three other competing hospitals; five, four other competing hospitals; and, six, five other competing hospitals? If you could submit that to the committee, I would appreciate it.

Ms. STEIGER. We will do the best we can to at least answer generally, if we can't use fact-specific material, but we certainly will respond.

Senator HATCH. Thank you.

In order to see whether the hospitals' claims of randomness are correct, without identifying transactions or hospitals by name, could you provide a document containing a list of the total number of hospitals that made Hart-Scott applications and other hospital merger investigations in markets with six or less hospitals during the beginning with your agency's first challenge to a hospital merger? Could you do that?

Ms. STEIGER. Let us see how well we can do, and if we can't do exactly that, Senator, we will try and explain why we can't. I am hesitating only because you have added those not filed under Hart-Scott-Rodino, but let us do the best we can to satisfy you.

Senator HATCH. That will be fine. Thank you. For each transaction, I would like you to identify the market share you calculated for each transaction; the efficiencies you have calculated, if any; the views of the employers and insurers toward the merger; and any other ameliorating facts, if you would. And for each of the listed transactions, would you please state whether there was a second request for additional information or a challenge to the proposed transaction, or whether the hospitals discontinued the proposed transaction during the time that it was pending. If you could do that, I would appreciate it.

Ms. STEIGER. Again, we will do our best. There may be some nonpublic considerations of material there, but we will be back to your staff on those matters.

Senator HATCH. OK, thank you. A January 1993 GAO report says that in Rochester, NY, hospital costs are 30 to 40 percent lower, in large part as a result of joint agreements involving hospitals to limit overcapacity and duplication of technology. In Rochester, business leaders, local government officials, health providers, and health insurers have worked cooperatively to develop and

maintain a regional system. Hospitals make decisions on major capital investments as a group.

Now, if we know that reduction in the growth rate of health care costs is one of the goals of health care reform, we know from recent GAO reports like this one entitled "Health Care: Rochester's Community Approach Yields Better Access, Lower Costs" that some types of provider collaborations do, in fact, yield lower costs.

The antitrust laws are designed to protect the consumer. If that is so, why does the FTC insist, as it did in the eleventh circuit case of *FTC* v. *University Health Inc.,* that efficiencies should not be a defense to antitrust claims? For instance, in this case it is said the appellees argue that the proposed acquisition would generate significant efficiencies and therefore would not substantially lessen competition. The FTC responds that the law recognizes no such efficiency defense in any form. Why do you take that position, or do you?

Ms. STEIGER. The eleventh circuit did opine that these efficiencies, while not a defense, were a matter of active consideration, but that they had to be specific rather than mere assertions of efficiencies, and I think that is what that record shows. I mentioned earlier in response to a question by the chairman, I believe, that we take efficiencies very seriously, but they should be specific to the transaction being brought forward. They should be able to be identified and shown to be passed on to consumers, particularly when there are anticompetitive concerns raised by the rest of the record.

Senator HATCH. Well, the court does say that efficiencies should be taken into consideration, but the reason I raise it is because it says that the FTC takes the position that the law recognizes no efficiency defense in any form. Is that really the position of the FTC?

Ms. STEIGER. As a defense, I think that is the position.

Senator HATCH. As a defense, yes.

Ms. STEIGER. The merger guidelines clearly indicate consideration of efficiency, the 1992 guidelines, and we do consider efficiencies, again with the clear caveat that they must be merger-specific. And, remember, you do not get to the consideration of efficiencies unless you have already come to the question of whether there is not an antitrust problem.

Senator HATCH. But then you do recognize them as a form of defense, then?

Ms. STEIGER. We consider all efficiency defenses brought to us. All too often, unfortunately, we are not given specifics, nor specifics that relate to the transaction at hand.

Senator HATCH. Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much, Senator Hatch.

Senator Thurmond?

Senator THURMOND. Thank you, Mr. Chairman. Chairman Steiger, we are glad to have you with us.

Ms. STEIGER. Thank you, Senator.

Senator THURMOND. It seemed clear from your testimony that enforcement of the antitrust laws has been important to allow development of health care alternatives in the past. However, the health care reforms now being discussed focus on greater cooperative efforts in order to achieve efficiencies. In such circumstances,

do you believe that some changes in the antitrust laws or enforcement will be necessary?

Ms. STEIGER. I think, without reference to specific proposals or plans since we haven't studied them yet and some of them are to be forthcoming, as long as there is a role for competition in the provision of health care there will remain an important role for antitrust.

We certainly don't say that antitrust enforcement is the answer to the problems of the health care community, in toto. It is not, but it has played an important role in opening up the health care market for alternative methods of health care delivery, against opposition in the past, and I think it remains as a bulwark against anticompetitive or collusive collaborative behavior. This will remain the case.

I haven't seen any specific proposal, but I think antitrust will remain important as long as there is an element of competition within the various proposals that will be brought forward.

Senator THURMOND. Madam Chairman, if the Department of Justice were to act favorably on the Pharmaceutical Manufacturers Association's request for a business review letter, as a practical matter, would the Commission be unlikely to challenge the Association's plan to limit price increases?

Ms. STEIGER. We have a system of clearance for the examination of matters that we have mutual jurisdiction over, and that matter is cleared to Justice at this point in time, so I would simply await the Justice Department's decision on that matter. I do note that a new policy of the Justice Department recently announced indicated they were making every attempt to respond to such requests within 90 days, so I presume the answer will be forthcoming shortly from the Department of Justice.

Senator THURMOND. Thank you, Mr. Chairman. That is all the questions I have.

Senator METZENBAUM. Thank you very much, Senator Thurmond. Thank you very much, Ms. Steiger, and thank you for being with us.

I don't think we put your name into the record.

Ms. STEPTOE. Mary Lou Steptoe.

Senator METZENBAUM. And your position?

Ms. STEPTOE. I am the acting director of the Bureau of Competition.

Senator METZENBAUM. Thank you very much.

Ms. STEIGER. We thank the committee for the opportunity to appear, Senators.

Senator HATCH. Good to see you.

Senator METZENBAUM. We are happy to have both of you with us this morning.

[Ms. Steiger submitted the following:]

PREPARED STATEMENT OF HON. JANET D. STEIGER

Mr. Chairman and members of the Subcommittee: I am pleased to appear before you today to present the testimony of the Federal Trade Commission on the relationship between antitrust enforcement and health care reform.[1]

There is intense interest in proposals for containing the rapidly increasing cost of health care in the United States. I am not, of course, in a position to discuss any particular proposal,[2] but as Chairman of an agency that has for years been an advocate and defender of the role of competition in health care, I want to discuss an element that has figured prominently in the reform discussions to date—reliance on competition in the health care field, including the development of managed care and other alternative delivery plans.

I have two principal points. First, antitrust enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. Commission enforcement actions have challenged anticompetitive rules that prohibited physician affiliation with health care plans, and have halted organized boycotts by some health care providers against newly developing health care arrangements.

Second, continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care reform. I will not suggest that any particular antitrust exemption would doom any particular health care plan. However, proposals for broad statutory antitrust exemptions that are now being advocated by some provider groups could frustrate the drive to contain rising health care costs. Experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and to thwart cost reductions.

The FTC enforces the antitrust laws to ensure that competitive forces will allow the development of health care delivery desired by consumers. The Commission does not favor one type of health care delivery system over another. Instead, the Commission endeavors to keep markets competitive so that consumers may choose whatever health care option they prefer. We do not advocate that consumers choose a managed care plan over a fee-for-service health care plan. Nor does the Commission take a position on which kind of health care plan provides better quality health care at lower prices. Instead, we try to level the playing field so that each plan may develop and grow as they meet the wants and needs of consumers. The Commission seeks to ensure that anticompetitive behavior does not impede or block the development of health care alternatives that consumers might elect to use. This background on the function of the Commission in enforcing the antitrust laws is a useful starting point for understanding our role in this process.

Through sound antitrust enforcement the FTC has helped allow market forces to create an environment in which innovative forms of health care delivery could emerge to compete on the merits. In that competitive environment, these alternative health care delivery systems grew as consumers were attracted by the services or lower prices these plans offered. The concepts that form the foundation for some of today's reform proposals were greatly facilitated by antitrust enforcement.

Before I develop these points in greater detail, however, let me offer a general caveat. Although I firmly believe that antitrust enforcement has been and will continue to be an important factor in allowing for the development of a more cost- effective health care delivery system, antitrust cannot, and will not, alone solve the problem of controlling health care costs. My suggestion is a more modest one: that antitrust has a role to play in fostering competition in health care markets and thereby facilitating other cost containment efforts. I believe that the Federal Trade Commission will continue to play a significant, constructive role in this process.

I. THE CONTRIBUTION OF ANTITRUST ENFORCEMENT TO THE DEVELOPMENT OF HEALTH CARE PLANS

Understanding the role that antitrust enforcement has played during the last two decades in opening health care markets to new forms of competition requires an historical perspective. Until the late 1970's, most physicians practiced solo, fee-for-service medicine. There were few alternative arrangements. Even multi-specialty group practices were rare, and health care plans that sought to compete by signing up a

[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and response to questions are my on, and do not necessarily represent the views of the Commission or any individual Commissioner.

[2] The Administration's Health Care Reform Task Force is currently scheduled to announce its proposals during May.

limited panel of selected physicians were impeded by a variety of restrictions. Most hospitals operated in a similarly independent fashion, with few limitations on what they could charge.

The early forerunners of today's managed care arrangements met with opposition. Some physicians who associated with such plans were the targets of reprisal, facing charges of unethical conduct, expulsion from local medical societies, and loss of hospital privileges.[3] In 1943, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early health maintenance organization.[4] The associations had taken disciplinary actions against Group Health staff physicians, imposed sanctions against doctors who consulted with Group Health physicians, and threatened disciplinary action against hospitals at which Group Health doctors were permitted to practice.

Notwithstanding the Supreme Court's decision, providers of alternative health delivery systems, and physicians who associated with them, continued to face opposition to their activities. In 1975, the Commission issued an administrative complaint challenging the AMA's ethical standards. The complaint alleged that the AMA's ethical restrictions prohibited physicians from providing services to patients under a salaried contract with a "lay" hospital or Health Maintenance Organization ("HMO"), "underbidding" for a contract or agreeing to accept compensation that was "inadequate" compared to the "usual" fees in the community, and entering into arrangements whereby patients were supposedly denied a "reasonable" degree of choice among physicians. In 1979, the Commission held that all of these restraints violated the antitrust laws.[5]

HMO's and other managed care plans attempt to achieve cost-effectiveness by limiting the provider panel to those known to provide the desired quality of care, giving this limited panel incentives to control costs, and in some instances exercising direct supervision over the appropriateness of the course of treatment selected. While patient choice is limited once the patient has enrolled in such a plan, the existence of these plans allows the purchasers to decide whether the cost savings the plans offered are worth accepting their limitations. But prohibitions of "inadequate" fees or requirements of "reasonable" provider choice can impede the ability of these plans to operate effectively.

The advertising aspect of the Commission's *AMA* case also benefited consumers. Doctors had been prohibited by the AMA's ethical rules from disseminating truthful information to the public about the price, quality, or other aspects of their services (such as office hours, acceptance of Medicare assignment or credit cards, use of Spanish-speaking staff, or house-call services).[6] The Commission found that this ban on truthful advertising had a particularly adverse impact on newly emerging plans such as HMO's, which needed to advertise precisely because they were novel, and thus unfamiliar to consumers.[7] The ability to advertise is particularly important to a new market entrant.

Even after the Commission's *AMA* case freed physicians to affiliate with health care plans, these plans often continued to face boycotts by providers. While some providers join managed care plans, and many others compete against them on the merits, our experience shows that some providers have engaged in illegal concerted action to resist new forms of competition. The Commission has taken action to remedy conduct such as obstructing hospital privileges for HMO physicians[8] and boycotting a hospital that was planning to open an HMO facility.[9]

Within the last two years alone, the Commission has issued a series of orders against alleged threatened boycotts by physicians in the Fort Lauderdale, Florida, area to prevent local hospitals from pursuing affiliation with the Cleveland Clinic.[10] The Cleveland Clinic is a nationally known provider of comprehensive health care services. The Clinic, which operates as a multi-specialty group medical practice, offers a predetermined "global fee" or "unit price" covering all aspects of many serv-

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[3] *See* P. Feldstein, Health Associations and the Demand for Medical Care 40–44 (1977).

[4] *American Medical Ass'n* v. *United States*, 317 U.S. 519 (1943).

[5] American Medical Ass'n, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982).

[6] *See Id.* at 846–48. *See also* Broward County Medical Society, 99 F.T.C. 622, 624 (1982) (consent order).

[7] 94 F.T.C. at 1006.

[8] Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order).

[9] Medical Staff of Doctors' Hospital of Prince Georges County, 110 F.T.C. 476 (1988) (consent order).

[10] Diran Seropian, M.D., Dkt. No. 9248, 57 Fed. Reg. 44,748 (1992) (consent order); Medical Staff of Holy Cross Hospital, C–3345, 56 Fed. Reg. 49,184 (1991) (consent order); Medical Staff of Broward General Medical Center, C–3344, 56 Fed. Reg. 49,184 (1991) (consent order).

ices, such as surgery. The Commission's complaints alleged that when the Clinic sought to establish a facility in Florida, local physicians sought to prevent its physicians from gaining hospital privileges by threatening to boycott the hospitals. Our orders prevent such activity from recurring.

The Commission also played an important role in taking enforcement action to end barriers to the emergence of independent health care prepayment plans. The first medical and hospital prepayment plans—forerunners of today's Blue Cross and Blue Shield plans—were outgrowths of state or local medical societies and hospital associations. These groups initially had direct control of the plans, but in the early 1970's the Blue Cross plans began to split off from the hospital associations. Provider control of Blue Shield plans lasted longer. An important factor in the debate about provider control of Blue Shield plans was a Commission staff report detailing evidence that medical societies had used control of the plans to increase physicians' fees and to obstruct competition from non-physician providers and from health care plans.[11]

One of the first Blue Shield plans to become independent of a medical society was Blue Shield of Michigan. Once independent, this plan introduced several proposals to contain the rising cost of physicians' services. The state medical society responded by forming a "negotiating committee" that orchestrated boycotts of the plan to defeat cost containment. In *Michigan State Medical Society,* the Commission prohibited such joint "negotiations."[12]

The Commission has since enjoined a number of other conspiracies to obstruct cost containment measures, in cases such as *Federal Trade Commission* v. *Indiana Federation of Dentists,*[13] where the Supreme Court unanimously affirmed a Commission decision halting a conspiracy among dentists to frustrate a cost containment program by withholding dental X-rays from insurers. The refusal to provide the X-rays frustrated the cost containment effort by preventing the efficient operation of utilization control mechanisms.[14] More recently, we obtained a consent order that required the dissolution of an allegedly "sham" venture among physicians who were not economically integrated but simply operated to conduct joint negotiations to defeat the cost reduction initiatives of third-party payors.[15]

Also important to health care cost containment is the preservation of competition among institutional providers of health care services, including hospitals. Thus, our review of hospital mergers, as I will discuss later, helps to maintain competitive conditions that enable consumers and health care plans to choose among competing alternatives.

The antitrust enforcement actions I have just described by no means exhaust the categories of the Commission's efforts to preserve competition and thus expand the variety of health care plans, particularly more cost-containment options. For example, the Commission has brought cases that challenged unjustified restrictions on the delivery of health care services by non-physician providers, such as nurse-midwives or podiatrists.[16] The Commission does not side with non-physicians against physicians, or vice versa, of course, but seeks to ensure that consumers have the opportunity to choose between them. In general, antitrust enforcement seeks to ensure that physicians and non-physician professionals are able—so far as possible—to compete on a level playing field. The resulting expanded range of choice benefits both health care plans and individual health care consumers.

The Commission has also acted against provider efforts that directly sought to frustrate cost-containment programs. The Commission has entered several consent orders with associations of pharmacies and their members that had allegedly organized boycotts to thwart third-party-payor attempts at cost containment, by jointly threatening to withdraw as providers from the payors' prescription drug benefit programs unless the pharmacies' compensation demands were met.[17]

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[11] Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans, Staff Report to the Federal Trade Commission (1979).

[12] 101 F.T.C. 191, 296, 313–14 (1983).

[13] *Federal Trade Commission* v. *Indiana Federation of Dentists,* 476 U.S. 447 (1986).

[14] *Id.* at 461.

[15] Southbank IPA, Inc., C–3355, 57 Fed. Reg. 2913 (1992).

[16] For example, the Commission prohibited boycotts of nurse midwives (State Volunteer Mutual Ins. Corp., 102 F.T.C. 1232 (1983) (consent order)) and podiatrists (North Carolina Orthopaedic Ass'n, 108 F.T.C. 116 (1986) (consent order)).

[17] *E.g.,* Southeast Colorado Pharmacal Ass'n, C–3410, 57 Fed. Reg. 52,631 (1993) (consent order); Peterson Drug Company, No. D–9227 (1992) (Commission adopted opinion of administrative law judge after appeal withdrawn); Chain Pharmacy Ass'n, No. D–9227, 56 Fed. Reg. 9223 (1991); Orange County Pharmaceutical Soc'y, No. C–3292, 55 Fed. Reg. 31,441 (1990) (consent orders).

Commission enforcement in pharmaceutical markets has not been confined to pharmacy boycotts. Last year, the Commission issued an order preventing Sandoz Pharmaceutical Corporation from "tying" its antipsychotic drug, clozapine, to a blood testing and monitoring service.[18] This action likely saved the Department of Veterans Affairs, one major purchaser of clozapine, $20 million a year.[19]

Last year, two leading manufacturers of infant formula settled Commission charges that they had engaged in unilateral facilitating practices to eliminate competitive sole-source bidding in the federal government's Women, Infants, and Children (WAC) program in Puerto Rico. The manufacturers agreed to refrain from such actions in the future and to provide restitution in the form of 3.6 million pounds of free infant formula to the U.S. Department of Agriculture, which administers the WAC program.[20]

Finally, I would be remiss if I did not mention some of the merger cases brought by the Commission in the health care area. In addition to the hospital merger cases, which I will discuss later, in the last three years the Commission has entered into consent orders restructuring transactions among firms producing such diverse health care products as dental amalgams, human growth hormone, and wheelchair lifts.[21] By preventing transactions that are likely to reduce competition and lead to higher prices in a broad spectrum of health care markets, the Commission's merger enforcement contributes to the overall health care cost containment effort.

II. ANTITRUST EXEMPTIONS AND HEALTH CARE REFORM

Just as sound antitrust enforcement has contributed significantly to the growth of alternative arrangements in the health care sector, so it is likely to be an important underpinning of future reform. Our experience in health care markets has shown that, without the protection that antitrust law provides, efforts to contain health care costs sometimes can be frustrated by the opposition of certain providers.

Nonetheless, there have recently been a variety of proposals to create special antitrust exemptions for collective action by hospitals and physicians. Some seek an exemption for mergers and various kinds of joint ventures from antitrust scrutiny. Others seek an exemption for various forms of concerted action—in particular, collective negotiations with health care purchasers and payors. Without getting into the specifics of any proposal, I want to explain the reasons for concern about exemptions in this area.

At their core, the proposed exemptions for physicians and hospitals may be based on questionable arguments about the nature of competition in health care markets and how antitrust law applies to physicians and hospitals. One argument is that due to market imperfections, competition in health care does not work to contain costs and ensure quality. The other argument is that antitrust law is not flexible enough to deal with markets, such as many health care markets, that may not resemble perfect competition. In our view, however, the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is flexible enough to prevent harmful conduct without interfering with efficient joint conduct that benefits consumers.

A. Hospital exemptions

Recently, Congress has considered a number of proposals for special antitrust exemptions for hospital mergers and joint ventures. Certain groups have proposed legislation that would allow hospitals, under some circumstances, to obtain antitrust immunity for combining their operations, or sharing medical services or equipment.

Is there a need for this type of legislation? The proponents pose two arguments. First, they contend that due to widely perceived uncertainty about the antitrust laws' prohibitions, efficient mergers and joint ventures among hospitals are prevented or inhibited. Second, and more broadly, they contend that there is an inher-

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[18] Sandoz Pharmaceutical Corp., C–3385, 57 Fed. Reg. 36,403 (1992) (consent order).

[19] This was one of two tying cases brought by the Commission. In the other case, the Commission prohibited the owner of certain renal dialysis clinics from using a tying arrangement to circumvent Medicare reimbursement limits on outpatient dialysis services. Gerald S. Friedman, No. C–3290, 55 Fed. Reg. 27,686 (1990) (consent order).

[20] *FTC* v. *Mead Johnson & Co.*, No. 92–1366 (D.D.C. June 11, 1992) (consent order); *FTC* v. *American Home Products Corp.*, No. 92–1365 (D.D.C. June 11, 1992) (consent order). The Commission is also pursuing allegations of price fixing against a third manufacturer which did not agree to settle the Commission's allegations. *FTC* v. *Abbott Laboratories*, 1992–2 Trade Cas. (CCH) par. 69,996 (D.D.C. 1992).

[21] Dentsply International, Inc., C–3407, 58 Fed. Reg. 6796 (1993) (consent order); American Stair-Glide Corp., C–3331, 56 Fed. Reg. 26,108 (1991) (consent order); Roche Holding Ltd., C–3315, 55 Fed. Reg. 53,191 (1990) (consent order).

ent conflict between the antitrust laws and demands to contain costs by eliminating unnecessary duplication of services and facilities. We believe that the available evidence fails to support their assertions.

Sound antitrust enforcement does not hinder efficient, procompetitive collaborations. Let me put the issue in perspective. In a typical year, there are about 50 to 100 hospital mergers or other arrangements consolidating previously independent hospitals. Review of these transactions by Commission staff normally entails minimal or no direct contact with the parties and no delay in the transaction beyond statutory Hart-Scott-Rodino requirements. In the past decade, the Commission has conducted only about two dozen formal investigations, mostly involving larger metropolitan hospitals, and has challenged, on average, less than one hospital merger a year.

Our assessment of the impact of antitrust enforcement on hospital collaborations has been confirmed by some others. Hospital merger and joint venture activity has been so vigorous that a recent article in *Modern Healthcare* was entitled "Mergers Thrive Despite Wailing About Adversity."[22] After an examination of the record, the article dismissed the claim that antitrust enforcement inhibited hospital consolidation. Similarly, a Department of Health and Human Services task force recently examined the claim that enforcement agencies have become too adversarial in challenging hospital mergers, concluding that the assertion was not supported by the evidence.[23]

The HHS task force specifically addressed the issue of rural hospital mergers, which has been the subject of some attention of late. It found that there was no evidence that the possibility of scrutiny by the antitrust enforcement agencies adversely affected consolidation among hospitals in rural markets. The task force also found that very few such mergers are investigated, and concluded that there was "no need to exempt and therefore tacitly encourage mergers among hospitals in rural or 'small' urban settings."[24] We believe that the task force report supports our contention that antitrust enforcement does not inhibit efficient mergers in the hospital area.

The enforcement record on hospital joint ventures similarly should not evoke concern. To date, the Commission has not challenged a single joint venture among hospitals. Indeed, in the context of our merger enforcement, we have expressly allowed various types of hospital joint ventures that are not likely to raise serious antitrust concerns. In a recent order blocking a hospital merger in a highly concentrated market, the Commission exempted from the order's reporting requirements any prospective joint ventures the hospitals might decide to undertake to provide data processing, laboratory testing, and health care financing.[25] These joint ventures appeared likely to achieve efficiencies and improve specific services, without endangering price and quality competition for other competitive services, as a complete merger could.

The great majority of hospital mergers and joint ventures—like those in most lines of business—do not endanger competition. Most hospital mergers do not pose a threat to competition because they occur in markets with a substantial number of competitors. Indeed, many hospital mergers may enhance efficiency and promote competition.

Similarly, many hospital joint ventures are off efficiency-enhancing. Joint ventures can make new technologies available to communities that otherwise could not have them and can spread the cost of ownership of expensive equipment among competing providers. But joint ventures need not be confined to the acquisition of expensive technologies. They may also facilitate the provision of essential services to a community. Thus, it may not be surprising that most hospitals engage in some

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[22] *Modern Healthcare*, Oct. 12, 1992, at 30.

[23] *Report of the Secretary's Task Force on Hospital Mergers*, at 11 (Jan. 1993). The report noted that between 1987 and 1991 the FTC and the Justice Department investigated only 27 of 229 hospital mergers and challenged only 5 transactions.

[24] *Id.* at 9.

[25] University Health, Inc., FTC Docket No. 9246, 57 Fed. Reg. 29,084, 44,748 (1992) (consent order) (exempting a wide range of support service joint ventures). *See Federal Trade Commission* v. *University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991) (upholding FTC challenge to acquisition of hospital). *See also* The Reading Hospital, FTC Docket No. C–3284, 55 Fed. Reg. 3264, 3266, 15,290 (1990) (consent order) (the Commission determined that voluntary separation of the merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in hospital-sponsored health plan joint ventures, and to share laundry, laboratory and biomedical equipment repair services).

forms of joint venture activity. To cite but one example, virtually all hospitals acquire many of their day-to-day supplies through buying cooperatives.[26]

But the fact that most hospital mergers and joint ventures are procompetitive does not mean that there is no place for antitrust enforcement in hospital markets. Some transactions involving hospitals are anticompetitive, and the Commission seeks to ensure that health care consumers have a sufficient selection of competing providers to be able to shop for the best possible bargain.

In our hospital merger investigations, we examine a broad range of evidence concerning the likely impact of the merger on health care costs. We do not rely on market concentration figures standing alone. One of several factors to be examined is the views of buyers of hospital services including insurance companies, health care plans, and large employers. In many of these investigations, these buyers have stated that competition among hospitals is important because it permits them to get better deals. When we review hospital mergers, we consider whether the merger will help or hurt payors and health care plans in their attempts to hold down cost increases. If hospital mergers are exempted from the antitrust laws, hospitals may be able to acquire market power and resist such cost-containment efforts.

Finally, let me address the argument that merger enforcement in the health care area actually leads to higher, not lower health care costs. The argument we hear with increasing frequency is that competition among hospitals should not be encouraged because it leads to costly duplication of services and facilities. This argument was made to the Commission by Hospital Corporation of America in defense of a proposed merger a few years ago. The Commission found that the argument was contradicted by a great deal of evidence in that case, including internal hospital documents stating that "increasing competition in the health care sector * * * will allow natural market forces to slow the price spiral."[27]

The Commission's experience in merger enforcement in the health care area has demonstrated that often procompetitive mergers can result in the elimination of duplication of services. In some circumstances, elimination of redundant underutilized facilities can improve the effectiveness of operating those that remain. The Commission is aware, however, that care must be given to ensure that eliminating duplication of services does not become simply avoiding competition.

B. Exemptions for professionals

Current proposals for an antitrust exemption for physicians focus on physicians' dealings with purchasers and payors of health care services. Today many physicians compete to be selected by one or more health care plans. Through this competition among physicians, plans seek to employ enough quality physicians without paying unnecessarily high prices. One exemption supported by certain health care professionals would permit competing physicians to eliminate competition by joining together and, without engaging in any risk sharing or integration of their practices or finances, collectively bargaining with large purchasers and payors of health care services.

Purchasers and payors that represent a large number of consumers may have sufficient clout and knowledge to bargain aggressively with physicians and other health care providers to obtain lower charges and adherence to a variety of cost-containment measures. An exemption allowing sellers of health care services to aggregate for bargaining purposes may, however, enable providers to defeat legitimate cost containment efforts.

The argument for exempting health care providers' joint bargaining from antitrust scrutiny is based on the questionable premise that health care purchasers possess market power and can therefore artificially depress health care prices. In most markets, however, there appear to be a large number of medical care alternatives, including Blue Cross and Blue Shield plans, numerous commercial insurers, HMO's, and other firms that offer health insurance or benefits. In the absence of market power on the part of large purchasers and payors, permitting physicians to aggregate their power would not create a "counterbalance," but rather could give physicians unconstrained market power and the ability to raise prices for health care services. Even in circumstances in which the number of payors is limited, we are not aware of any evidence to suggest that allowing physicians to collaborate in negotiating prices will lead to any benefits to consumers.

But we need not rely on theories to see what happens when provider groups collectively "negotiate" with payors and purchasers. A good example is the *Michigan*

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[26] *See Nearly All Hospitals Use Group Purchasing,* Modern Health Care, Dec. 24–31, 1990, at 40.

[27] Hospital Corp. of America, 106 F.T.C. 361, 478–87 (1985), *aff'd,* 807 F.2d 1381 (7th Cir. 1986), *cert. denied,* 481 U.S. 1038 (1987).

State Medical Society case I mentioned. To satisfy consumers, the plan needed to have contracts with a large enough number of physicians who would agree to accept the plan's payment as payment in full. The plan relied on competition among physicians to obtain the right number and mix of physicians, but physicians agreed among themselves that they would not compete over the terms they would accept from Blue Shield. Instead, these physicians agreed that none of them would join the plan unless and until the plan responded to the demands of the medical society.

No antitrust exemption is necessary for physicians to serve, individually and collectively, as forceful advocates for their patients and profession; that is clearly legal under the antitrust laws. But as the Commission and court decisions make clear, the collective judgment of health care providers concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace. The point is straightforward. Physicians can engage in forceful advocacy and provide information to health plans without an antitrust exemption.[28] The Commission has made clear in its remedial orders governing physician boycotts that physicians may nonetheless jointly provide information to payors (or insurers).[29] But an antitrust exemption for "collective negotiations" could permit providers to override consumer choice and harm our economy.

Lately we have also heard the claim that antitrust enforcement interferes with responsible self-regulation by groups of health care providers, and that antitrust prevents such groups from addressing problems of fraud and abuse. Let me assure you that this simply is not the case. Antitrust law does not prevent professional associations from disciplining or expelling members who do not meet minimal quality of care standards, or who engage in false, deceptive, or other abusive behavior. Many Commission orders involving health care professionals contain provisions explicitly permitting the regulation of false and deceptive dissemination of information.[30] As the Commission emphasized in its 1979 opinion in the *AMA* case, professional associations "have a valuable and unique role to play" regarding deceptive and oppressive conduct by their members.[31]

Before leaving the subject of self-regulation, let me also say a brief word about the AMA's request for an FTC advisory opinion on peer review of doctor's fees by medical societies, because I have heard several public references to it recently. More than a decade ago the Commission approved the concept of advisory fee review by professional organizations.[32] Such programs can provide valuable information to patients and others who pay for medical care, and, as long as they are properly structured, present no antitrust concerns. The AMA has asked the Commission to approve a type of fee review that goes beyond the kind of peer review that has been approved in the past, because it would involve not only the provision of information to consumers about the reasonableness of specific fees, but also possible disciplinary action against physicians in certain circumstances.

In order to analyze the AMA's proposal, several months ago the Commission's staff asked the AMA to provide additional information and to clarify certain aspects of the proposal. It is my understanding that the information has been received and that FTC staff and AMA representatives conferred in late February. This new information is now under review and the Commission intends to resolve the matter expeditiously.

CONCLUSION

I thank the Committee for the opportunity to present this testimony. I will now be happy to answer your questions.

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[28] The Commission's Analysis of Proposed Consent Order to Aid Public Comment in the *Chain Pharmacy Association* matter illustrates this distinction. Chain Pharmacy Ass'n of New York State, Inc., Dkt. No. 9227, 56 Fed. Reg. 12,534, 12,541 (1991).

[29] *See, e.g.*, Southbank IPA, Inc., C–3355, 56 Fed. Reg. 50912, 50914 (1991); 57 Fed. Reg. 2913 (1992); Rochester Anesthesiologists (formerly Jose F. Calimlim, M.D.), 110 F.T.C. 175, 180–81 (1988) (consent order); Michigan State Medical Society, 101 F.T.C. 191, 307–08, 314 (1983).

[30] *See* American Psychological Ass'n, C–3406, 58 Fed. Reg. 557 (1993) (Commissioner Azcuenaga concurred in part and dissented in part); National Association of Social Workers, C–3416, 57 Fed. Reg. 61,424 (1992) (Commissioner Stark dissented).

[31] American Medical Ass'n, 94 F.T.C. at 1029.

[32] Iowa Dental Ass'n, 99 F.T.C. 648 (1982) (advisory opinion approving proposal of dental association to institute a peer review program which would aid the cost containment efforts of third-party payers, so long as the fee review program was voluntary and non-binding, guidance in particular disputes was not disseminated to members generally as an indication of appropriate pricing, and the judgments of the peer review panel did not proceed from pre-agreed price standards).

FEDERAL TRADE COMMISSION,
Washington, DC, April 28, 1993.

JAMES S. TODD, M.D.
Executive Vice President,
American Medical Association, Chicago, IL.

DEAR DR. TODD: I am writing in response to your March 23, 1993, letter concerning my February 19th speech before the National Health Lawyers Association. I appreciate hearing your thoughts. I firmly believe in the importance of a constructive dialogue between the FTC and AMA, and I invite you to let me know whenever you have concerns about views I have expressed. Since I understand that on March 23, AMA representatives also delivered a copy of your letter to the Senate Judiciary Committee's Antitrust Subcommittee, I will send a copy of my response to the Subcommittee and other interested parties.

As you may imagine, I was surprised and concerned by your statement that my speech "distort[ed] the facts" and made "self-serving misstatements of AMA actions." I have interpreted your charge as a request that I review the support for the characterizations I used in my remarks. I have done so with some care. I believe my statements fairly reflect the factual record.

You argue first that I was mistaken in stating that the Commission's 1975 case against AMA was necessary to eliminate the impediments to the development of managed care plans that resulted from the AMA "contract practice" rules. In support of your claim, you state that although the AMA's 1971 edition of the *Opinions and Reports of the Judicial Council* contained "unfortunate statements on contractual relationships," these "statements" did not in fact represent the "post-World War II views of the AMA." Indeed, you say that "[a]ny AMA-imposed restrictions on the ability of physicians to contract with [managed care] plans had ended before 1950."

My review confirms the following facts. First, the 1971 edition of *Opinions and Reports* was not AMA's last official publication of the bans on contract practice. In 1974, AMA included these rules and a reaffirmation of its "established policy" barring contractual arrangements between physicians and "any hospital, corporation or lay body", including health care delivery organizations in its *Report on Physician-Hospital Relations. American Medical Ass'n,* 94 F.T.C. 701, at 896, 897 (1979), *aff'd,* 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court,* 455 U.S. 676 (1982). Furthermore, in 1977, AMA counsel formally advised the Commission that AMA's current position on contract practice is "best reflected * * * in the 1974 *Report on Physician-Hospital Relations.*" 94 F.T.C. at 1026–27.

Moreover, what you call "unfortunate statements" in the 1971 edition of *Opinions and Reports* were in fact official AMA interpretations of a binding ethical rule. For example, AMA formally declared it "unethical" for physicians to contract with a health maintenance organization (HMO), hospital, or clinic "when compensation received is inadequate based on usual fees" in the community, or when there is "underbidding." 94 F.T.C. at 896. The U.S. Court of Appeals for the Second Circuit expressly found that substantial evidence supported the finding that:

> AMA's contract practice restrictions had the purpose and effect of restraining competition by group health plans, hospitals, and similar organizations, and restricted physicians from developing business structures of their own choice.

638 F.2d at 449.

AMA's contract practice rules had these anticompetitive effects even without formal enforcement by AMA itself, due to concerted action by AMA and its member societies. AMA's structure contemplated that its member societies would enforce AMA's ethical rules. 94 F.T.C. at 997. Moreover, the AMA Judicial Council counseled member societies on application of the contract practice bans, thus promoting adherence to them. *Id.* at 900–907. For example, in the mid-1960's the Secretary of the AMA Judicial Council wrote to a local society that:

> The Judicial Council believes that the remedy for the evils associated with contract practice resides in the county societies, and that these societies should use their influence and power * * * to prevent underbidding for these contracts below what would give a fair reward for medical services rendered.

Id. at 901–02.

Even after the 1975 FTC complaint against AMA, state and local societies continued to enforce AMA's contract practice rules. Until at least mid-1977, AMA member societies in Florida used AMA's rules to impede the development of a federally

qualified HMO. *Id.* at 906–907. And the Texas Medical Association explicitly relied on AMA's contract practice rules in declaring in 1975 that the only "ethical" way for physicians to charge is on a fee-for-service basis. *Id.* at 905.

In addition, although actual enforcement was by AMA member societies, AMA itself repeatedly reaffirmed its anticompetitive contract practice rules well after 1950. For example, as noted at 94 F.T.C. 900–07:

(1) In 1974, the Secretary of the AMA Judicial Council wrote in response to an inquiry that it would be "contrary to the long established policy of the AMA" for a physician to be paid on an hourly basis by a clinic.

(2) In 1973, the AMA Department of Field Services directly assisted the Florida societies in combatting the development of an HMO in their area by supplying "anti-HMO's" information "[which] will give you and your physicians all the necessary information and 'ammunition' to rebut HMO activities in your area."

(3) In 1973, the Secretary of the AMA Judicial Council advised a state medical association that a plan to pay physicians a salary would violate "ethical principles," citing the contract practice rules of the 1971 *Opinions and Reports*.

(4) In 1972, the Secretary of the AMA Judicial Council cited AMA's contract practice rules in disapproving of the activities of a prepaid group health plan.

(5) AMA relied upon its contract practice rules on numerous occasions during the 1960's.

As you know, the contract practice rules were not eliminated from AMA's ethical code until after the FTC issued its complaint against AMA in 1975. You state that AMA voluntarily deleted the rules in 1977, following a review prompted by the 1975 *Goldfarb* decision. The Commission, however, in its 1979 decision in *American Medical Association* found no evidence that AMA or its Judicial Council considered modifying the contract practice rules prior to issuance of the FTC complaint. 94 F.T.C. at 1026.

Moreover, although your letter suggests that when the order was entered the rules had long since been disavowed by AMA, the Commission found, and the Second Circuit agreed, that an order banning such rules was necessary precisely because AMA had not disavowed its prior unlawful conduct and that the conduct could recur if it were not prohibited. 94 F.T.C. 1026–29; 638 F.2d at 451. It may well be that the degree of AMA's opposition to contract practice had lessened by the time of issuance of the FTC complaint, but the Commission found, after a full trial on the merits, that the ethical rules continued to have anticompetitive effects. In sum, there is ample support for my statement that the Commission's case against AMA freed physicians to join managed care plans and was one of the factors necessary for the development of such plans.

Your second claim concerning my speech is that I mischaracterized AMA's position in "stat[ing] (at pp. 9–11) that physicians attempted ten years ago, and are again attempting, to obtain 'special antitrust exemptions for collective action' that would suppress competition in dealing with purchasers of health care services."

With respect to AMA's legislative activities in 1982, you state that my speech "gives the impression that the AMA sought to exempt the medical profession from the antitrust laws in 1982." You assert that this is inaccurate because AMA was merely "seek[ing] to eliminate the jurisdiction of the FTC over the medical profession." In fact, my only mention of AMA's 1982 activities referred simply to the attempt, which you acknowledge, to exempt physicians "from all of the provisions of the Federal Trade Commission Act." But since you emphasize that AMA's 1982 "proposal" would have left the medical profession subject to other antitrust laws, I think it pertinent that in addition to seeking an exemption from the FTC Act, AMA in 1982 supported proposed legislation to amend the other antitrust laws—the Sherman Act, Clayton Act, and state antitrust laws—to give special, more lenient treatment to doctors.[1]

With respect to current proposals to enact special antitrust provisions for physicians, I understand that you dislike the term "exemption" and that you view such modifications as an important part of health care reform. That you perceive such changes to constitute beneficial reform does not alter the fact that they would indeed create special, more lenient antitrust rules for one industry, and are therefore appropriately termed special exemptions. Nor is it accurate to suggest, as your letter

[1] *American Medical News*, June 25/July 2, 1982 at p. 10 (reporting House of Delegates adoption of Board of Trustees Report Q on "Remedial Antitrust Legislation").

does, that I have attempted to avoid debate of the merits of such proposals by simply dismissing them with an invocation of the "exemption" label. Indeed, the thrust of my speech was to discuss the general nature of the proposals (we had no specifics at that time) and to examine the premises that underlie them, to further an open debate on these matters.

I would be happy to pursue discussions with AMA representatives about AMA's antitrust proposals and the concerns that they seek to address. Of course, such dialogue may not produce agreement about the desirability of AMA's proposals, but it would promote an understanding that could only benefit the policy-makers who must ultimately decide these issues. It would be useful, for example, to clarify AMA's repeated assertions that it does not want an exemption for price fixing in light of AMA's criticism of the Commission's *Southbank* case, FTC Docket No. C–3355 (1992) (consent order), which challenged alleged price fixing. Surely, a constructive discussion of such issues would be both possible and productive.

This point brings me to the troubling statement in your letter that you perceive recent signs of Commission hostility to legitimate activities of the medical profession. It has been one of my chief goals as Chairman of the FTC to alleviate unduly adversarial relationships between the FTC and those with whom it deals. Indeed, it has been my belief, and certainly my expectation, that FTC and AMA staff had developed a sound cooperative relationship on many issues of mutual interest, and that past misunderstandings had been laid aside. I am aware, for example, of the recent work FTC and AMA staff have done concerning issues involving deceptive advertising of physicians' services.

I am unable to comment about the particular matter mentioned on page 5 of your letter. When a complaint is made by a third person, my ability to reply is constrained because I cannot confirm or deny that an investigation of a specific party or matter exists. Ordinarily, when questions arise concerning an interpretation or a possible law violation, the appropriate Bureau reviews the issue. The staff typically makes a recommendation that it forwards to the Bureau Director. Only then will the appropriate Bureau Director send a recommendation to the Commission. No agency action occurs unless the Commission votes on the matter. Therefore, in any matter where you wish to provide input, I suggest that you contact the staff or appropriate Bureau Director. Many questions that arise can be resolved at the Bureau level. Ultimately, the Commission will address any unresolved concerns of the parties if it takes final action.

When I first came to the Commission, I met with you and your representatives to try to prevent future misunderstandings between the FTC and AMA. Let me extend an invitation to continue our dialogue with the same goal in mind. Since both of our organizations share a common concern in matters of great public interest, it is important that our channels of communication remain open and clear.

Sincerely,

(Signed) Janet D. Steiger

(Typed) JANET D. STEIGER,
Chairman.

Senator METZENBAUM. Our next panel is Clark C. Havighurst, William Neal Reynolds Professor of Law at Duke University; ValGene Devitt, president of the Ukiah Valley Medical Center; Vernon Rothschild, president of Rothschild's Orthopedics; and the Honorable Reginald Matthews, American Association of Retired Persons, of Sugar Land, TX.

We do have a 5-minute time limit for the presentations. Mr. Havighurst, we will be very happy to hear from you first.

PANEL CONSISTING OF CLARK C. HAVIGHURST, WILLIAM NEAL REYNOLDS PROFESSOR OF LAW, DUKE UNIVERSITY, DURHAM, NC; VALGENE DEVITT, PRESIDENT, UKIAH VALLEY MEDICAL CENTER, UKIAH, CA; VERNON R. ROTHSCHILD, PRESIDENT, ROTHSCHILD'S ORTHOPEDICS, SALISBURY, MD; AND HON. REGINALD S. MATTHEWS, AMERICAN ASSOCIATION OF RETIRED PERSONS, SUGAR LAND, TX

STATEMENT OF PROF. CLARK C. HAVIGHURST

Mr. HAVIGHURST. I am Clark Havighurst, Mr. Chairman. I teach antitrust law and health care law at the Duke University School of Law. I have a longstanding interest in the problem of applying the antitrust laws to the health care industry. Indeed, I appeared before this subcommittee in, I think it was 1974 when Senator Hart held rather extensive hearings on this subject before the *Goldfarb* case, and I think we launched a very useful enterprise at that time and we have come a long way since. As my statement reflects, I think it has been a generally useful undertaking to apply the antitrust laws actively to this industry.

The hearing comes at a critical point in the history of this industry. It appears that in the near future the President will propose a major transformation of American health care. Although only the outlines of this new policy are yet clear, it seems certain that competition in the health care sector, which has heretofore been maintained only under the general oversight of the antitrust laws, will soon become a whole new ball game.

From all reports, the reforms to be proposed will include implementation of the policy called managed competition. This new policy will include explicit emphasis on making competition more effective by structuring consumer choices among organized accountable health plans, AHP's, in local markets and by making such plans more effective competitors both for patients and for the services of providers.

The concept of managed competition contemplates that competition will be conducted under a new set of rules specially developed for the health care field and will be refereed by a new crew of umpires called HIPC's, or the health insurance purchasing cooperatives. Clearly, the President's forthcoming proposals promise to usher in an important new chapter in the history of competition as an instrument of social control and resource allocation in American health care.

Although the future of competition in health care under the impending reforms is a matter of great interest and importance, the more immediate concerns have apparently occasioned today's hearing. Certain groups in the health industry—specifically, physician organizations, hospitals, and pharmaceutical manufacturers—have alleged that there is currently a serious mismatch between the requirements of antitrust law, actual or perceived, and wise public policy.

The view being expressed in various ways by each industry group is that antitrust law prevents or inhibits, through the vagueness of its requirements, industry members from pursuing courses of action that would serve the public interest better than unrestricted

competition. It is appropriate that this subcommittee listen carefully to the issues being raised.

Although antitrust law has contributed greatly to improving the competitiveness of the health care field, a combination of perverse incentives, disorganization—particularly on the purchaser side, but also on the provider side—unaccountable purchasers, and the complex economics of health care markets have so far prevented competition, as enforced under the antitrust laws, from being the final answer to the problem of getting the health care sector to perform efficiently.

The issues that are before the subcommittee today are symptomatic of the shortcomings of health care markets as they currently operate. But even though the issues before the subcommittee today deserve a full hearing, it would, in my view, be inappropriate for Congress to consider making any specific response to them, particularly the requests for antitrust exemptions, at this time.

The impending appearance of the Clinton administration's reform proposal featuring managed competition as one cornerstone, obviously makes premature any serious consideration of antitrust exemptions for specific players in the competitive game. Until there is a new opportunity to consider the specific role of antitrust law in controlling play in this new ballpark of managed competition, it seems to me there is an insufficient basis for Congress to make the policy judgments that would be needed to grant the relief that these groups are requested.

It is not too soon, however, it seems to me, for the subcommittee to begin speculating on how this new game of managed competition will be played. Indeed, it is useful to try to visualize how the issues being addressed in this hearing would play out in the future, on the assumption that managed competition will soon be the name of the game.

Now, I have speculated in my prepared remarks on these questions with respect to each of the three proposals before you and I would like to quickly try to summarize quickly where I come out. I won't be able to give you the full feel for my sense of this.

With respect to physicians, I do have some sympathy with their frustration in having to deal with powerful payers, both public and private, but I don't see any justification for a change in antitrust law with respect to physicians. Antitrust law allows physicians to organize themselves into alternative health plans, which we will now call AHP's or accountable health plans, and specifically discourages them from taking collective action that is aimed at manipulating the existing financing system, which is essentially what they have been doing for years and which has caused many of our problems, first by controlling the Blue Shield plans and on down the road through IPA's, and so on, and it seems to me that the antitrust laws are pushing the doctors in just the right direction.

Under managed competition, the pressure on physicians to integrate themselves into effective, competing groups, AHP's, will intensify. There is some reason to hope, I think, that physicians will find their professional lives more satisfying in that setting where they are working in collegial groups to try to offer better services to people at reasonable cost. It seems to me that is where we must be headed. That is what managed competition is trying to promote,

and it seems to me that the AMA's proposals to the committee today don't recognize that that is where we must head soon. I wish the AMA was helping the profession to find ways to organize AHP's rather than try to fight this rear-guard action to protect fee-for-service as we have known it.

My statement makes a major point of the need under managed competition to preserve active competition among AHP's in obtaining provider services, not only in competing for patients. Specifically, I argue that HIPC's should confine themselves to managing competition procompetitively and not to engage in exercising monopsonistic power against providers. Indeed, I think the HIPC's should themselves be subject to the Sherman Act as purchaser combinations, and thus forced into performing the procompetitive function of managing competition and discouraged from just simply ganging up on providers.

So I don't see any need for an exemption or special treatment for physicians, but I do see an obligation on Congress' part not to let managed competition become a euphemism for the uncontrolled exercise of government-sponsored monopsony power against physicians and hospitals. I think if we fail in providing that protection, doctors will then have a good claim for an antitrust exemption and indeed for the right to strike, and I hope we will never come to that in America.

May I continue, Senator, to talk about hospitals or do you want to ask a question?

Senator METZENBAUM. Take another minute, if you would, please, Mr. Havighurst.

Mr. HAVIGHURST. All right. On hospitals, I do think that they shouldn't be given antitrust relief until we see how managed competition develops. I agree that antitrust law does not yield easy answers to the problems that are presented by mergers and joint ventures in concentrated markets.

The agencies, I think, however, are asking the right questions and doing a conscientious job in trying to preserve competition where it is preservable. I think they are right to seek to preserve enough hospitals in a given area that organized health plans will be able, if they develop, and haven't yet, to shop for hospital care in competitive markets. That is what they are trying to do. I think it is useful.

Managed competition will speed the development of these alternative purchasers and intensify competitive pressures on hospitals. The HIPC's will be new players in the antitrust game. Their assessments of the local circumstances—is this procompetitive, anticompetitive, are the efficiencies worth having—will be of great help to the antitrust enforcement agencies in making the calls that are so hard to make today. I think their assessments of the effects of mergers will be at least influential, and perhaps ought to be given more weight than that.

Senator METZENBAUM. Can you wind up, please, Mr. Havighurst?

Mr. HAVIGHURST. Where competition has to be sacrificed in order to achieve efficiency, it seems to me that the HIPC could be in a position of exercising more of a kind of a regulatory power under those very limited circumstances where you, in fact, have a monopoly hospital. My statement goes into that in greater length.

On the PMA issue, I have a sense that Justice would be justified in making a policy choice not to push the issue at this point in aid of the administration's health reform proposal. In other words, let the industry put some voluntary restraints on their own price increases until management competition is in place. Managed competition is going to change that industry dramatically. We are going to have very wise purchasing of prescription drugs once organized doctors in organized groups are making hard calls, and cost-conscious calls, about how to use drugs effectively. They are going to have bulk purchasing. You are going to have very thoughtful spending decisions made not by individual doctors who have to be marketed one by one, but by doctor groups conscientiously concerned about both cost and quality for their patients.

I think that it is within the President's power to have the Justice Department grant this temporary exemption, on the condition that harmful effects don't appear.

Thank you, sir.

[Mr. Havighurst submitted the following:]

PREPARED STATEMENT OF PROF. CLARK C. HAVIGHURST

Mr. Chairman, I am Clark Havighurst. I teach antitrust law and health care law at the Duke University School of Law. I have a long-standing interest in the subject of this hearing—the application of antitrust law to the health care industry. I appreciate the opportunity to discuss this subject with you.

This hearing comes at a critical point in the history of the health care industry. It appears that, in the near future, the President will propose a major transformation of American health care. Although only the outlines of the new policy are at all clear, it seems certain that competition in the health care sector, heretofore maintained only under the general rules of antitrust law, will soon become "a whole new ball game." From all reports, the reforms to be proposed will include implementation of a policy called "managed competition." This new policy will include explicit emphasis on making competition more effective by structuring consumer choices among organized, "accountable" health plans (AHP's) in local markets and by making such plans more effective competitors for the services of providers. The concept of managed competition contemplates that competition will be conducted under a new set of rules specially developed for the health care field and will be refereed by a new crew of umpires called health insurance purchasing cooperatives (HIPC's). Clearly, the President's forthcoming proposals promise to usher in an important new chapter in the history of competition as an instrument of social control and resource allocation in American health care.

Although the future of competition in health care under the impending reforms is a matter of great interest and importance, more immediate concerns have apparently occasioned today's hearing. Certain groups within the health care industry—specifically, physician organizations, hospitals, and pharmaceutical manufacturers—have alleged that there is currently a serious mismatch between the requirements of antitrust law, actual or perceived, and wise public policy. The view being expressed in various ways by each industry group is that antitrust law prevents, or inhibits through the vagueness of its requirements, industry members from pursuing courses of action that would serve the public interest better than unrestricted competition. It is appropriate that this subcommittee listen carefully to the issues being raised. Although antitrust law has contributed greatly to improving the competitiveness of the health care field, a combination of perverse incentives, disorganization, unaccountable purchasers, and the complex economics of health care markets has so far prevented competition, as enforced under the antitrust laws, from being the final answer to the problem of getting the health care sector to perform efficiently. The issues that are before the subcommittee today are symptomatic of the shortcomings of health care markets as they currently operate.

But even though the issues before the subcommittee today deserve a full hearing, it would, in my view, be inappropriate for Congress to consider making any specific response to them at this time. The impending appearance of the Clinton administration's reform proposal, featuring managed competition as one cornerstone, obviously makes premature any serious consideration of antitrust exemptions for specific players in the competitive game. Until there is an opportunity to consider the specific

role of antitrust law in controlling play in the new ballpark of managed competition, there is an insufficient basis for the policy judgments needed to grant the relief that these industry groups are requesting.

It may not be too soon, however, for the subcommittee to begin speculating on how the new game of managed competition will be played. Indeed, it is useful to try to visualize how the issues being addressed in this hearing would play out in the future, on the assumption that managed competition will soon be the name of the game. I attempt to speculate on such matters in these remarks. I hope that this heuristic mind-game will not only assist the subcommittee, but will also be helpful to those who are designing the new policy. I have already had an occasion to consider the role of antitrust law under managed competition in a memorandum I prepared for the White House Task Force on Health Reform. I am submitting for the record a slightly revised version of that memo, entitled "HIPC's and the Antitrust Laws." I hope that it will assist the subcommittee in guiding Congress's action on the health reform proposal with a view to ensuring that antitrust law is appropriately incorporated in the new rules. (I should state that the memo contains no "inside" information concerning the deliberations of the Task Force, about which I am just about as ignorant as everyone else.)

I. INTRODUCTION: ANTITRUST LAW IN THE HEALTH CARE SECTOR

Mr. Chairman, in considering requests for exemptions from, or special treatment under, the antitrust laws, the subcommittee should remember the immense benefits that antitrust law has brought to consumers of health care in the relatively short time since it was brought to bear on their behalf. It was only in 1975, of course, that the Supreme Court, in the *Goldfarb* case, overturned the long-standing assumption that the Sherman Act did not apply to the so-called "learned professions," as it does to other types of "trade or commerce." The application of antitrust law to health care providers following *Goldfarb* dramatically altered the character of the health care industry. Anticompetitive concerted action by providers—which had previously been accepted as an immutable feature of the industry—suddenly became unlawful. With physicians and other providers no longer permitted to enforce their preferences by collective action, purchasers of health care gained new opportunities to bargain with them. HMO's, PPO's, and other managed-care arrangements began to prosper in the 1980's, and selective contracting gave purchasers for the first time some leverage in dealing with physicians and hospitals. Thus, many dramatic changes in the health care market that we now take for granted would not have occurred if the antitrust laws had not protected and encouraged innovation. These benefits of active antitrust enforcement need to be kept in mind in considering requests for exemptions.

The *Goldfarb* holding that professionals do not enjoy an implied exemption from the antitrust laws also had far-reaching implications for the course of American health policy. Perhaps the most important thing it did was to reverse the presumption, implicit in previous national policy, that competition could serve no useful purpose in the health care sector. In addition, by making antitrust law newly available to prevent physicians and other providers from conspiring to limit competition, the Court's decision gave market-oriented health policy proposals new credibility in national policy debates. It was no coincidence that policymakers began in the late 197O's to place substantial reliance on competition to discipline health care markets. The 1980's, in turn, saw substantial progress in reorganizing health care financing and delivery along more efficient lines and in making health care the subject of effective price bargaining. There is every reason to expect, with managed competition in the offing, that the 199O's will build on the progress of competition in the 198O's by capturing its best elements and by eliminating the distorted incentives, the confusion of consumers, and other constraints on responsible economizing that still prevent consumer choice and competition from ensuring optimal industry performance.

In my view, Mr. Chairman, it is hard to overestimate the contribution that antitrust law and competition have made to bringing us to the point where, with the introduction of managed competition to smooth some edges and sharpen others, competition and consumer choice may soon be reliable instruments for achieving efficiency in the delivery of health care and guiding the nation's health care spending.

II. IS MANAGED COMPETITION AN OXYMORON?

The fate of competition under a policy of managed competition will be partly in the hands of the HIPC's. The powers of these new players in the health care marketplace will in turn depend upon their statutory mandate, including any special antitrust rules enacted to govern their conduct or the conduct of AHP's and provid-

ers competing in their respective markets. Some observers apparently contemplate that the main *raison d'etre* of HIPC's will be to aggregate the purchasing power of consumers for the purpose of exercising monopsony power over providers. The original architects of managed competition, however, had a more limited goal in mind—namely, that HIPC's will ensure that effective competition is maintained on both sides of the market so that the competitive process will operate efficiently and fairly for both consumers and providers. Some skeptics, who might be content to see the latter vision realized but doubt that government is truly interested either in letting the market work or in fairness to providers, have characterized managed competition as an "oxymoron." It is to be hoped that managed competition will not prove to be merely a euphemism for the uncontrolled exercise of government-sponsored monopsony power against physicians and hospitals.

One way to ensure that HIPC's confine their efforts to managing competition and do not give in to the temptation to exploit providers would be to make certain that the antitrust laws apply to the HIPC's themselves. Although the nature and governance of HIPC's have not been finally determined, there are good reasons for them to not to be governmental entities but instead to take the form of what political scientists call a "quango" (a quasi-autonomous nongovernmental organization). For example, I visualize a HIPC as a true consumer cooperative, organized as a not-for-profit corporation controlled (not necessarily through periodic contested elections) by its members, the consumers who purchase coverage under its auspices. If HIPC's are constituted in roughly this way, they will qualify as combinations of their members and thus be subject to scrutiny under section 1 of the Sherman Act. Whatever their precise form, however, I would hope that all HIPC's would be subject to antitrust law.

It seems clear that most, if not all, HIPC actions that are subject to the Sherman Act would be examined under the so-called Rule of Reason rather than under a so-called "per sea" rule (which does not permit the defense that the challenged practice was more procompetitive than anticompetitive in the particular circumstances). According to the leading case on the subject, "The true test of legality [of restrictive concerted action under the Rule of Reason] is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Board of Trade* v. *United States,* 246 U.S. 231 (1918). This language strongly suggests that a HIPC engaged in managing competition to improve the working of the market—by providing information, structuring choices, inducing AHP development, and removing opportunities for risk selection—would rather easily pass muster under the Rule of Reason. The *Chicago Board of Trade* case itself upheld agreements among competitors that, although limiting competition in some minor respects, significantly strengthened it in others—by creating a central auction market for commodities. The HIPC's task of managing competition would seem "procompetitive" in precisely the same sense.

Nevertheless, because HIPC's will usually be in a position to exercise a great deal of monopsony power in dealing with health plans and in purchasing health services, HIPC's subject to the Sherman Act should anticipate especially close antitrust scrutiny of their day-to-day practices. The task of an antitrust court would be to ensure that a HIPC pursues only its legitimate, procompetitive purposes and does not give in to the temptation to exercise its buying power to dictate terms to health plans and providers. In other words, HIPC's would be required to confine themselves to managing competition procompetitively and would be subject to antitrust attack if their actions had the effect of denying providers the benefit of buyer competition for their services.

There would certainly be some cases, however, in which it would be desirable for HIPC's to step out of their procompetitive role of managing competition and to exercise monopsony power as a kind of regulatory body dictating terms to health plans or providers. It is anticipated, for example, that many markets will not immediately be effectively competitive. In addition, some HIPC's will encounter product markets or even whole regions in which competition among providers is not working well because of collusion or monopoly. Rural areas in particular may lack enough competitors to make competition workable in all health services. In such circumstances, Congress might wish the HIPC to be able to confront the situation directly, as a powerful buyer, without exposing itself (or the health plans cooperating with it) to antitrust liability.

In my view, express provision should be made for allowing a HIPC to assume regulatory powers upon finding certain noncompetitive conditions to exist. One way to confer such powers would be to make provision for individual HIPC's to operate under annual contracts with the National Health Board (or whatever entity is created to administer managed competition) and to grant antitrust immunity for actions taken pursuant to such contracts. The use of such contracts, individually nego-

tiated, would allow HIPC's to initiate their own moves to improve the performance of their local markets, while also giving federal authorities an opportunity to review assertions by individual HIPC's that they need regulatory power to redress noncompetitive situations. The federal overseers, perhaps in consultation with the federal antitrust enforcement agencies, might sometimes conclude that antitrust enforcement against providers or health plans, rather than price dictation by the HIPC, was the preferable remedy for the situation encountered or might see room for other kinds of procompetitive solutions. In some cases, however, HIPC's would be allowed to deal in regulatory ways with situations in which, even with good management, competition was not working well. On the other hand, whenever a HIPC had not been expressly authorized in this way to expand its powers, I believe the antitrust laws should be retained as a check on HIPC's that abuse their buying power. Provision should probably be made, however, for eliminating the treble-damage sanction against HIPC's, with its undue inducement for nuisance suits.

Mr. Chairman, although this is just one view of how the playing field of managed competition might look, I would encourage you to visualize how the industry players before you today would fare in the competition ahead. Obviously, we should all be looking to ensure that the playing field is level for all competitors and especially for consumers.

III. PHYSICIANS, ANTITRUST LAW, AND MANAGED COMPETITION

I have not been a supporter of the AMA's periodic requests for exemption from the antitrust laws to allow physicians to combine for the naked purpose of bargaining collectively with health plans. I am sympathetic, however, with the frustration that individual physicians feel in contending with powerful payers. Indeed, I fear that some utilization managers, instead of implementing careful review of individual treatment decisions on the medical merits, rely primarily on the "hassle factor" to induce doctors to do less for their patients than they would otherwise do. Even if this strategy could be shown to work well in discouraging inappropriate expenditures without appreciable harm to patients, one should regret the burdens placed on the integrity of individual professionals. I, for one, would not deny that physicians have some justification for protesting the burdens of such oversight, the offense to their professional pride, and the threat posed to the quality of care.

Despite the validity of some physician complaints about life under competition as we know it, however, it would be inappropriate to confer an antitrust exemption on them. Such an exemption would necessarily restrict bargaining over all factors in the competitive equation, including price, and would not necessarily advance the larger public interest. Physicians have available to them already the option of joining together in health plans that are operated in a manner more in keeping with their professionalism. Such plans must, of course, be able to compete in the marketplace on the basis of both price and quality, and antitrust law blocks the formation of plans whose main purpose is to eliminate competition or dominate the market. The current antitrust tests for evaluating physician joint ventures (PPO's, IPA's, etc.) look to the degree of practice integration and risktaking and to whether the collaborating doctors are offering, in the words of one leading case, a "different product." I see no reason to question the appropriateness of these tests or the manner in which they are applied by the enforcement agencies. It is quite appropriate for physicians to be under competitive pressure to organize new competitive entities in which cost containment is achieved in professionally satisfying, but also consumer-satisfying, ways.

One of the leading objectives of managed competition will be to induce significant integration and reorganization of health care financing and delivery through the creation of AHP's. The lesson of the last decade is that such reorganizations do not come easily and that a great deal of sophistication and constant pressure from the demand side of the market are needed to obtain the kinds of reforms that providers and payers, left to their own devices, are slow to volunteer. The needed changes are likely to occur only if physicians are not empowered to resist collectively any changes they dislike. On the other hand, physicians should enjoy protection against HIPC's that, instead of engaging in procompetitive, market-reform actions, seek simply to exercise monopsony power unfairly.

There are good policy reasons (besides simple fairness) for maintaining antitrust law as a protection for providers against the exercise by HIPC's of undue buying power in local markets. Faced with HIPC-sponsored buying power that was unassailable under the antitrust laws, providers could argue, with much greater plausibility than they now can, that antitrust law should not deny them the opportunity to exercise countervailing power through collective bargaining. Indeed, physicians would have a strong claim that they should be given the right to strike when faced

with demands that they regard as offensive or unfair. (One can only hope that the administration's reform proposal will not be so potentially unfair to providers as to raise the prospect of doctor strikes as a regular feature of American health care.) Even though some observers have been attracted to the bilateral-monopoly model of bargaining over health care (such as is found in some foreign systems, where antitrust law does not apply to professionals and doctor strikes are not unknown), that model is not implicit in, or even compatible with, the concept of managed competition.

In its pure form, managed competition can be presented to providers as a basically fair program under which, like nearly everyone else, they would have to compete for business. Indeed, managed competition can be accurately portrayed as a way of ensuring that there will always be a number of health plans competing actively for providers' services and therefore responsive to their concerns. On the other band, a decision to give the HIPC's explicit legal authority to exercise or mobilize monopsony power against providers would forfeit the program's appearance of neutrality and strike many persons besides providers as manifestly unfair. The credibility of managed competition as a reform program could be quickly lost if an antitrust exemption made it seem to be not a vehicle for making providers and health plans compete fairly and reasonably, but a vehicle for exploiting providers. By the same token, granting all antitrust exemption to physicians would give HIPC's a stronger claim to act in a regulatory rather than a procompetitive mode.

IV. HOSPITAL MERGERS AND JOINT VENTURES

Hospitals can make an especially appealing case for some modification of the current antitrust regime. It is a regrettable circumstance that hospital mergers and joint ventures present analytical problems of the most difficult kind under the antitrust laws. Hospitals often exist in highly concentrated markets, making any mergers or collaboration in which they engage highly suspect under conventional antitrust doctrine. At the same time, many hospital services are provided very inefficiently because the payment system has not effectively penalized inefficiency and duplication. The task of the antitrust agencies or courts in reviewing a proposed merger or joint venture is to balance the need for some rationalization of the provision of hospital services against the loss of competition that might result. Because both the efficiencies to be gained and the competition to be lost are highly speculative in most cases, both the proponents of a transaction and the antitrust agencies themselves often lack any firm ground on which to stand. This analytical uncertainty makes antitrust law both an unsatisfying and a less than wholly satisfactory tool for answering the questions that these transactions necessarily raise.

Many industry observers find it difficult to understand why antitrust enforcers are so often reluctant to allow a hospital merger or collaboration when there is so little evidence that unbridled competition among hospitals benefits consumers. Nevertheless, antitrust enforcers resist some mergers or joint ventures not because they prize highly the type of competition that exists—largely nonprice (cost-increasing) competition to attract doctors rather than normal competition to attract consumers—but because they can visualize a more productive, efficiency-enhancing form of competition down the road and do not want to see that competition foreclosed before it has had a chance to develop. Specifically, the antitrust agencies have sought to preserve the possibility that, as more tightly organized health plans such as HMO's and PPO's emerge, they will be able to shop for hospital services in markets where there are more than one provider willing to compete for their business. If hospital competition is to work at all, hospitals must compete for groups of patients effectively represented by organized health plans. Although it is my perception that hospital competition of this kind occurs in larger geographic markets than are sometimes used evaluating hospital mergers, the antitrust agencies have been right to cling to the vision that real and effective price competition, rewarding efficiency and penalizing duplication, will eventually arise even in markets with relatively few hospitals.

Preserving the possibility that meaningful, cost-reducing competition will develop among hospitals is particularly important with managed competition on the horizon. An essential goal of the managed competition strategy is to inspire the creation of AHP's and to strengthen their incentives to shop for provider services with close attention to price and quality. This strategy will succeed in fewer places if antitrust officials have given in too often to hospitals' claims that efficiency can be achieved only through merger and that competition only contributes to the problem of inefficiency and rising costs.

From the beginning of the antitrust campaign to clear the way for competition in health care, the policy challenge has been to get the demand side of the market or-

ganized, under correct incentives and with appropriate agents representing consumers, so that the signals sent to the supply side induce efficiency and cost containment. The managed competition strategy offers a realistic potential for meeting that challenge in the foreseeable future. Antitrust enforcement in the meantime should continue to preserve the possibility of effective, cost-conscious competition even where it has yet to emerge. For this reason, too, Congress would not be justified in acting favorably at this time on the hospitals' current request for antitrust relief.

Even after managed competition is in place, antitrust analysis of proposed hospital mergers and joint ventures will continue to be difficult. Although managed competition will more clearly justify the antitrust agencies in anticipating the emergence of AHP's, the tradeoff between (speculative) efficiencies and (speculative) effects on future competition will be no easier to resolve. In markets where the number of hospitals is already small, the future ability of AHP's to purchase hospital services in an effectively competitive market will already be in doubt. Any increase in concentration will presumably increase the danger of coordinated pricing and other collusive behavior. At the same time, it will often seem desirable for hospitals to merge, share facilities, or otherwise rationalize services without having to compete to the death in every subcategory of services. The analytical task of balancing the procompetitive and anticompetitive effects of mergers and joint ventures will not be made easier by managed competition.

But even though the managed competition strategy will leave many antitrust judgments still uncertain, it promises to provide a valuable new source of assistance and advice for the antitrust enforcement agencies. HIPC's, as overseers of competition in local markets, will be in an ideal position to advise the antitrust authorities on the probable competitive effects of mergers and competitor collaboration. Because HIPC's will have good information and a direct interest in both efficiency and maintaining price and quality competition, they should be able to make the critical tradeoffs with more accuracy and confidence than the agencies or the courts. As suggested earlier, they may also be in a position, in the event that efficiency-enhancing collaboration eliminates effective competition, to shift into a regulatory mode to ensure that the noncompetitive service is supplied on appropriate terms.

In analyzing hospital mergers and joint ventures, the antitrust agencies already follow the practice of consulting large purchasers of care in the affected markets. Under managed competition, they would could be relied upon to give weight to the judgment of a concerned HIPC that was properly alert to the benefits of competition and sophisticated enough to appreciate the threats to it. If it was thought necessary to give HIPC's a more formal role in adjudicating antitrust issues, the health reform legislation might make the local HIPC's an official forum for addressing questions about local transactions. In my view, however, it would be preferable to keep the antitrust agencies as the final arbiters of whether mergers or joint ventures should be publicly challenged. In consulting with individual HIPC's, the agencies could perform a useful function in educating the latter, which cannot be assumed at the outset to be attuned to all the virtues of competition or to all the ways it can be restrained.

Properly educated in these respects, HIPC's will also be able to identify antitrust violations by providers or health plans in their local markets and to take action against them. HIPC's might initiate private antitrust actions as plaintiffs or, alternatively, let the FTC or the Justice Department police any violations they uncover. The kinds of conduct that might be challenged include price-fixing and other anticompetitive agreements, mergers, joint ventures, facilitating practices, and monopolistic practices such as tying arrangements, predatory pricing, and use of most-favored-nation clauses to foreclose opportunities of competing health plans.

V. PHARMACEUTICAL PRICES

The Pharmaceutical Manufacturers Association has pending before the Justice Department a request for a business review letter blessing a plan it has recently put forward for an industrywide program of voluntary self-restraint in pricing pharmaceutical products. Such a maximum-price-fixing agreement would probably be unlawful, although there has never been a definitive ruling on whether the so-called *Noerr-Pennington* doctrine might immunize an industrywide agreement to restrain price increases that was aimed solely at warding off a threat of government price regulation or other legislation that the industry opposes. In any event, the Justice Department could, I believe, exercise its prosecutorial discretion to express an intention not to prosecute the industry for maintaining such an agreement for a limited period of time. This position could be taken in aid of the Clinton administration's policy of facilitating a smooth transition to managed competition and universal health coverage. The Department should, of course, satisfy itself that there would

be no harmful effects on consumers. The Department's letter would not preclude private parties (if any have standing) or the FTC from taking action on their own, and Congress might attempt to persuade the FTC to pursue the matter. Because the issue is more a political one (suggesting the applicability of the *Noerr-Pennington* doctrine) than a substantive one, I have no more to say on the wisdom of any action the Department might take.

I would like to point out, however, that price regulation of pharmaceutical products would be a highly short-sighted policy move by Congress at this time. There is great danger, in any event, in tampering insensitively with incentives for new product development in the pharmaceutical field. Moreover, the managed competition strategy has at least as much potential for improving the operation of the market for pharmaceutical products as it does for bringing reliable competition to markets for physician and hospital services. AHP's will be systematically forced by competitive pressures and by HIPC's into making more cost-sensitive decisions with respect to all medical care, including drug prescribing. As the freedom of individual physicians to prescribe drugs is narrowed by collective decisions within the AHP's, drug companies' marketing efforts will be redirected, and price competition will intensify. Through careful monitoring of research evidence, development of formularies, and bulk purchasing, AHP's should bring more effective competition to the market for prescription drugs.

I would advise the subcommittee that, with major health reform featuring managed competition on the horizon, Congress should not impose new price controls on the pharmaceutical industry. In light of this advice, having the Justice Department give the industry temporary authority to engage in voluntary self-restraint might be a particularly wise expedient. I hope that Congress will agree to engage in some voluntary self-restraint of its own until the scope and implications of the move for national health reform are much clearer than they are today.

Memorandum From Clark C. Havighurst to Walter A. Zelman, White House Task Force on Health Reform

HIPC's and the Antitrust Laws

This memo presents some preliminary thoughts about how the antitrust laws might constrain HIPC's in performing their anticipated functions and about what, if anything, should be done about such constraints in the legislation being drafted. It is impossible, of course, to provide a definitive catalog of the antitrust risks that HIPC's would face without knowing both (1) how they are to be governed—particularly whether they are to be true cooperatives, governed by the consumers or employers whose buying power they aggregate—and (2) the extent of their statutory authority to restrain trade. Nevertheless, a description of the antitrust risks that HIPC's would run if they functioned without any special statutory protection will be helpful in illuminating certain policy issues with which the Task Force must grapple. Once these policy issues are resolved, it should not be hard to draft the reform legislation in such a way as to remove antitrust obstacles that HIPC's would confront in performing their intended tasks.

ANTITRUST PRINCIPLES

The discussion here proceeds on the assumption that HIPC's will generally be engaged in concerted action of the kind that is subject to scrutiny under section 1 of the Sherman Act.[1] In reality, the governance of the HIPC might determine the ease

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[1] It seems improbable that section 2 of the Sherman Act (making it unlawful to "monopolize") would ever apply to a HIPC created pursuant to federal or state law. Certainly section 2 would not prevent the creation of a HIPC with substantial monopsony (buying) power if it was clear that federal policy supported the maintenance of such an entity in every market. Moreover, even though section 2 has been interpreted to prohibit "abuses" of lawful market power, the practice of charging high monopoly prices (or paying low monopsony prices) is not regarded as an abuse or "predatory practice" because it does not threaten to create new market power by excluding or adversely affecting competitors of the dominant firm. Cf. *Kartell v. Blue Cross of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985) (health insurer using the legitimately aggregated purchasing power of its many subscribers to dictate terms to physicians viewed, not as an unlawful monopsonist, but simply as a purchasing agent acting on behalf of others).

Antitrust law also contains no general requirement that a lawful monopolist controlling some market "bottleneck" or "essential facility" must deal (like a public utility) with all comers—or even with all comers who arguably meet its requirements, whatever they might be. No such duty exists even under the openended Federal Trade Commission Act. *Official Airlines Guides,*

or difficulty with which the requisite "contract, combination * * *, or conspiracy" could be established in a particular case. Thus, a coalition of employers or a true cooperative controlled by consumers would be most clearly vulnerable to challenge under section 1 because they are in fact combinations of purchasers. Nevertheless, other HIPC's that were not themselves horizontal conspiracies of market participants could easily be charged with entering into various kinds of "vertical" agreements or conspiracies with consumers or employers on the demand side of the market or with particular health plans or providers on the supply side. Although such charges might not always stick, they would have to be defended at substantial cost and with possibly uncertain outcomes. In any event, such differences in antitrust exposure ought not to dictate the decision on HIPC governance. For one thing, the applicability of antitrust law could be adjusted by the reform legislation. Moreover, the employer coalition and consumer cooperative models might be preferred precisely because, in addition to directly serving consumer interests (with fewer opportunities for destructive political influences), these models keep antitrust law available as a protection against certain anticompetitive abuses that all HIPC's however governed will be tempted to engage in.

It seems clear that most, if not all, HIPC actions that are subject to the Sherman Act would be examined under the so-called Rule of Reason rather than under a so-called "per se" rule (which does not permit the defense that the challenged practice was more procompetitive than anticompetitive in the particular circumstances). According to the leading case on the subject, "The true test of legality [of restrictive concerted action under the Rule of Reason] is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Board of Trade* v. *United States,* 246 U.S. 231 (1918). This language strongly suggests that an HIPC engaged in "managing" competition to improve the working of the market—by providing information, structuring choices, and removing opportunities for risk selection—would rather easily pass muster under the Rule of Reason. The *Chicago Board of Trade* case itself upheld agreements among competitors that, although limiting competition in some minor respects, significantly strengthened it in others—by creating a central auction market for commodities. The HIPC's task of "managing competition" would seem "procompetitive" in precisely the same sense. A statutory warrant to perform that task would only make the issue clearer.

In applying the Rule of Reason, the question sometimes arises whether a joint undertaking having a clear procompetitive purpose (a merger, for example) nevertheless endangers competition unduly because of its size and the market power it possesses in fact; thus, a joint venture with procompetitive features may sometimes be condemned because it is larger than necessary to achieve the efficiencies it promises. Because the size or scope of an HIPC will presumably be dictated by state or federal law, however, HIPC's will not be open to challenge on the ground of their size alone. Nevertheless, it remains the case that HIPC's will usually represent a very large proportion of the consumers in their respective markets and thus be in a position to exercise a great deal of monopsony power in dealing with health plans and in purchasing health services—much more than that exercised by virtually any employer or employer purchasing coalition today.[2] Consequently, HIPC's could anticipate especially close antitrust scrutiny of their day-to-day practices. The task of antitrust courts would be to ensure that HIPC's pursue only their legitimate, procompetitive purposes and do not give in to the temptation to exercise their buying power to dictate terms to health plans and providers. In general, unless HIPC's are given special antitrust dispensation by statute, they will be expected to adopt "less restrictive alternatives" in pursuing their legitimate objectives. In other words, they would be required to confine themselves to managing competition procompetitively and would be subject to antitrust attack if their actions had the effect of denying providers the benefit of buyer competition for their services.

Inc. v. *FTC,* 630 F.2d 920 (2d Cir. 1980), cert. denied, 450 U.S. 917 (1981) (FTC could not prohibit as "unfair practice" the refusal by a monopolist publisher of airline schedules to list flights of certain airlines). A monopolist might be held to have duties of this kind only when it has an independent commercial interest in—e.g., is vertically integrated into—the market in which the effects of its actions are felt. HIPC's presumably will have no such commercial interests and, therefore, having come by their monopsony power lawfully, probably have little to fear under section 2.

[2] In December, I completed an extensive memorandum of law for the John A. Hartford Foundation entitled "Antitrust Issues in the Joint Purchasing of Health Care by Employer Coalitions." That study concludes that employer coalitions will only rarely exercise enough market power over providers to create antitrust problems. HIPC's would almost certainly represent much more substantial aggregations of purchasing power.

As a practical matter, therefore, an HIPC would be generally barred from such activities as acting as the sole agent for accountable health plans in bargaining with providers. It would also run an antitrust risk if it should organize a cartel of health plans for the purpose of dictating prices to hospitals or doctors. It is not clear, however, that the antitrust laws, in blocking HIPC's in the naked exercise of buying power, would frustrate the achievement of any goal usually associated with the managed-competition initiative. There are many good reasons for better organizing the demand side of the market for health coverage that do not involve creating monopsony power to force providers to sell their services at lower-than-competitive prices. If it is desired to empower HIPC's to act in a more regulatory fashion in situations where competition is ineffective, the reform legislation can be drafted accordingly. Later discussion suggests how the legislation might permit HIPC's, under prescribed circumstances (such as where competition is demonstrably impaired by a provider cartel, tacit collusion, or a monopoly possessed by a dominant group practice or hospital), to shift from procompetitively managing competition into an explicit regulatory mode, with antitrust immunity.

There are some respects, however, in which an HIPC might run into antitrust difficulties in carrying out functions that even the most market-oriented managed-competition strategists might expect them to perform. Certainly, it is anticipated by many observers that HIPC's will screen accountable health plans for value (both quality and cost) before including them on the menu of offerings from which consumers will choose. A refusal to deal with a particular health plan could easily result, however, in an antitrust suit charging the HIPC with organizing an unlawful "boycott." Because the overall purpose of the HIPC is procompetitive, its refusals to deal would almost certainly be weighed under the Rule of Reason.[3] Unfortunately, however, the circumstances would sometimes be such that a plaintiff health plan could plausibly argue that the HIPC went beyond merely managing competition and sought to exercise its collective buying power either to obtain an unfair price advantage or to restrict the plaintiffs competitive freedom, unfairly denying it a chance to compete for consumers' favor on its own terms.

Some uncertainty could easily arise, for example, where an HIPC, acting as purchasing agent for consumers, rejected a plan because it found its price too high for the value offered or because it objected to some other term in the plan's contract.[4] It would not always be obvious in such a case whether the HIPC was acting procompetitively—as a surrogate decision maker for relatively unsophisticated consumers—or was attempting to exert collective buying power to drive prices below competitive levels. As long, however, as the HIPC did not employ its market power overtly or systematically to dictate the premiums of all plans (requiring plans, for example, to hold their premium increases for the next year to some arbitrary percentage), its occasional discretionary actions as a knowledgeable purchasing agent looking out for the welfare of its clients should pass antitrust muster. Thus, an antitrust court would probably not allow a HIPC to do what CalPERS (with significantly less market power than an HIPC is likely to exercise) recently did—namely, deny a particular health plan (Kaiser) the chance to enroll new subscribers for a year because its premium increase exceeded an arbitrary limit set by the "manager."

A slightly different set of antitrust issues would be raised by HIPC efforts to force the supply side of the market to accept unwanted organizational changes. One of the chief goals of managed competition is to reorganize financing and delivery systems by aggregating consumer demands for good quality at reasonable cost. The lesson of the last decade is that such changes do not come easily and that a great deal of sophistication and constant pressure from the demand side are needed to get the kinds of reforms that providers and payers, left to their own devices, are slow to volunteer. Nevertheless, health plans excluded from the market because they did not conform to the HIPC's requirements with respect to managed-care methods, quality controls, or compensation arrangements with providers are likely to bring antitrust actions premised on the notion that the HIPC is restraining trade and denying consumers options they might prefer. Although there is again a degree of

[3] The procompetitive character of the HIPC as a sophisticated agent designated to search the market on behalf of unsophisticated consumers should ensure that the HIPC's actions are examined under the Rule of Reason. Cf. *Northwest Wholesale Stationers* v. *Pacific Stationery & Printing Co.*, 472 U.S. 284 (1985).

[4] I assume here that the reform legislation will leave some room for contractual modifications of payer and provider obligations in providing prescribed benefits. I strongly believe (as you know from our previous communication) that the legislation should not prescribe all the terms of health plan contracts and should instead permit plans, with the consent of the HIPC, to modify their undertakings in the interest of responsible economizing.

antitrust uncertainty here, there is a reasonable prospect that courts, educated by the legislative history of the managed-competition legislation and influenced by the express assignment of reform responsibilities to HIPC's, would be able to distinguish between HIPCs' procompetitive, market-reform actions and any effort to exercise monopsony power unfairly against providers.[5]

SHOULD HIPC'S BE AUTHORIZED TO EXERCISE MONOPSONY POWER?

The foregoing observations concerning the limits placed by antitrust law on the activities of HIPC's raise sharply the policy question whether HIPC's should be expressly allowed by statute to exercise buying power in ways that antitrust law generally does not tolerate. Some observers, either misunderstanding the essential concept underlying managed competition or desiring to convert it into a more radical program, may believe that exercising buying power against providers should be the main *raison d'etre* of HIPC's. These observers will naturally assume that the reform legislation must include antitrust exemptions to facilitate monopsonistic buying. I believe, however, that explicitly conferring buying power on HIPC's would be an inappropriate and unnecessary policy move as well as a serious political mistake.

With respect to policy, it is not obvious that HIPC's should be free of antitrust constraints on their exercise of buying power. The theory behind the original managed-competition initiative was to improve consumers ability to demand better value for their money in a competitive market, thereby forcing the delivery system to reform itself in desirable ways. This distinctly procompetitive agenda can be accomplished without also empowering consumers and their agents to force providers to accept noncompetitive prices for their services. Moreover, the prototypes for managed competition—large employers and employer purchasing coalitions—have been able to achieve many of their objectives despite being subject to antitrust constraints and despite the fact that they do not aggregate nearly as much purchasing power as HIPC's are likely to possess.[6] Because federal sponsorship will protect HIPC's against antitrust attacks based on their size alone, there is all the more need for antitrust checks to ensure that HIPC's confine themselves to performing their procompetitive functions. Managed competition ought not to become a vehicle (or a euphemism) for the uncontrolled exercise of government-sponsored monopsony power against health care providers.

Providing a broad antitrust exemption for HIPC's might also be a political mistake, greatly complicating the task of getting the reform legislation adopted. Specifically, a proposal allowing HIPC's to exercise naked buying power would make credible otherwise incredible provider complaints about the bill's fairness. Indeed, a broad exemption for HIPC's would strengthen the AMA's currently weak argument for an exemption from the antitrust laws to allow physicians to combine for the naked purpose of bargaining collectively with health plans. Faced with HIPC-sponsored buying power that was unassailable under the antitrust laws, providers could argue with greater plausibility than ever before that antitrust law should not deny them the opportunity to merge or to exercise countervailing power through collective marketing. Indeed, physicians would have a strong claim that they should be given the right to strike when faced with demands that they regard as offensive or un-

[5] As long as the HIPC's goal was to force changes in the product being sold rather than merely to force reductions in the price of a standardized product (see note 4), it could fairly be said that, the HIPC was exercising merely bargaining power, not monopsony power. Economists object to monopsony power for the same reason they object to monopoly—because it reduces output below socially optimal levels. Although a HIPC's strategy in managing competition might well reduce output, that reduction would not necessarily be economically inefficient or harmful to consumer welfare, because consumers of health care have an affirmative interest in eliminating overutilization of health services. Indeed, the essential problem of health policy is that consumers have been getting too much of a good thing and have not had good contractual tools for buying less. Under a proper economic understanding, HIPCs' deployment of consumers' bargaining power to curb overutilization of health services would enhance consumer welfare rather than reduce it.

[6] In my recent memorandum for the Hartford Foundation (see note 2), I opined that, if a coalition possessed even a modicum of monopsony power in any market, its employer members would be required to retain and exercise their independent right to purchase health services outside the coalition (i.e., by offering employees options other than the coalition-negotiated plan). By extension, an HIPC representing a powerful combination of purchasers would not be permitted, without express statutory authority, to dictate prices to plans. It could, however, escape antitrust difficulties by maintaining a full range of competitively priced options among which consumers could choose.

fair.[7] (One should hope that the reform proposal will not be so potentially unfair to providers as to raise the prospect of doctor strikes.) Even though some observers may be attracted to the bilateral-monopoly model of bargaining over health care (such as is found in some foreign systems, where antitrust law does not apply to professionals and doctor strikes are not unknown), that model is not implicit in, nor even compatible with, the concept of managed competition.

In its pure form, managed competition can be presented to providers as a basically fair program under which, like nearly everyone else, they would have to compete for business; indeed, managed competition can be accurately portrayed as a way of ensuring that there will always be a number of health plans competing actively for providers' services and therefore responsive to their concerns. A decision to give the HIPC's explicit legal authority to exercise or mobilize monopsony power against providers would forfeit the program's appearance of neutrality and strike many persons besides providers as manifestly unfair. The credibility of managed competition as a reform program could be quickly lost if an antitrust exemption made it seem to be, not a vehicle for making providers and health plans compete fairly and reasonably, but a vehicle for exploiting providers.

CRAFTING A LIMITED ANTITRUST EXEMPTION FOR HIPC'S IN SPECIAL CIRCUMSTANCES

Fortunately, it is not necessary to choose between enacting a blanket antitrust exemption for HIPC's and leaving them subject to antitrust law in all circumstances they might confront. A more moderate and sensible policy would be to give HIPC's appropriate powers to deal with specific situations they may encounter, without empowering them to suppress competition in buying services in all cases, including those where competition among sellers is working well. There will certainly be some cases in which it will seem desirable for HIPC's to step out of their procompetitive role of managing competition and to exercise monopsony power as a kind of regulatory body dictating terms to health plans or providers. It is anticipated, for example, that many markets will not immediately be effectively competitive. In addition, some HIPC's will encounter product markets or even whole regions in which competition among providers is not working well because of collusion or monopoly; rural areas in particular may lack enough competitors to make competition workable in all services. In such circumstances, Congress might wish the HIPC to be able to confront the situation directly, as a powerful buyer, without exposing itself (or health plans cooperating with it) to antitrust liability.

A narrowly drawn provision authorizing an HIPC to assume regulatory powers upon finding certain noncompetitive conditions to exist would serve important public objectives without exposing the proposal to the charge that it is unfair to providers. I believe that I could draft some language striking the right balance on this issue. I might suggest, for example, having the Federal Trade Commission review assertions by individual HIPC's that they need regulatory power to redress certain noncompetitive situations in their assigned areas. Functioning in this oversight role, the FTC might sometimes conclude that antitrust enforcement against providers or health plans, rather than price dictation by the HIPC, was the preferable remedy for the situation encountered. In addition, the FTC might sometimes see room for other kinds of procompetitive solutions, such as encouraging health plans to designate hospitals in neighboring communities as preferred providers for certain services until the local hospital comes to better terms. In any event, HIPC's working with the FTC (or possibly with state officials acting in the same capacity) could perform useful public services in dealing with situations where, even with good management, competition was not working well enough to yield the benefits of managed competition. On the other hand, whenever an HIPC has not been authorized to expand its powers, I believe the antitrust laws should be retained as a check on HIPC's that abuse their buying power. Provision should probably be made, however, for eliminating the treble-damage sanction, with its undue inducement for nuisance suits.[8]

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[7] I, for one, believe and am prepared to argue—admittedly, without much support in the case law, but with some justice and theoretical validity—that the Sherman Act was not intended by Congress to apply to sellers' collective action when government has itself taken the transaction out of the competitive marketplace and systematically aggregated buying power against disaggregated sellers in ways immune to antitrust attack.

[8] I am strongly attracted by the idea of limiting the liability of HIPC's for treble damages, the usual remedy in private antitrust suits. Under the National Cooperative Research Act of 1984, certain types of joint venture that have been registered with the federal antitrust authorities, while not immune from challenge as antitrust violations, can only be held liable for ordinary damages (in addition to injunctive relief). An even better model for limiting the antitrust exposure of HIPC's, however, is probably the Local Government Antitrust Act of 1984. This law

HIPC'S AND ANTITRUST ENFORCEMENT

As overseers of competition in local markets, HIPC's will be in an ideal position to identify antitrust violations by providers or health plans and to take action against them. HIPC's might themselves initiate antitrust actions as plaintiffs, recovering treble damages and attorneys' fees and obtaining prospective relief either to control future conduct or to establish a competitive market structure. Alternatively, HIPC's might be required to let the FTC police any violations they uncover (referring cases suitable for criminal prosecution to the Justice Department). The range of violations that might be detected include price fixing and other anticompetitive agreements, mergers, monopolistic practices such as tying arrangements, predatory pricing, and use of most-favored-nation clauses to foreclose opportunities of competing health plans.

HIPC's might also perform useful functions in evaluating hospital mergers and various other kinds of mergers and joint ventures. Presumably an HIPC would be in an ideal position to advise on the probable competitive effects of a merger or competitor collaboration in its area. The hospital industry is currently seeking broader freedom to merge or consolidate operations, and it should be possible in the health reform legislation to expand their options in this regard and to limit their exposure to costly litigation by letting HIPC's resolve difficult questions, perhaps in consultation with the FTC. Because HIPC's will have a direct interest in efficiency as well as price and quality competition, they are ideally positioned to make the critical trade-offs.

Senator METZENBAUM. Thank you very much.

Mr. ValGene Devitt, president of the Ukiah Valley Medical Center, we are happy to have you with us, sir.

STATEMENT OF VALGENE DEVITT

Mr. DEVITT. Thank you, Senator. My name is ValGene Devitt. I am president of the Ukiah Valley Medical Center, a not-for-profit hospital located in Ukiah, CA. Ukiah is a small rural community of approximately 14,000 people located in Mendocino County, just over 100 miles north of San Francisco on Highway 101. The Ukiah Valley Medical Center is a 94-bed rural hospital.

I am here to tell you about our 4½-year odyssey that started in August 1988 when Ukiah Valley, then a 43-bed hospital, announced its plan to acquire the assets of Ukiah General Hospital, a 51-bed hospital in Ukiah, CA, and the FTC decided to investigate and challenge that transaction.

Anyone who has familiarity with the hospital industry knows that a 50-bed hospital is inefficient. As the economists would say, it is on the wrong side of the cost curve. Most health care professionals are incredulous when I tell them that the Federal Government has been prosecuting us based on the premise that this acquisition injured competition and might hurt consumers.

In the interests of the committee's time, I am going to make some brief statements and would request that I be permitted to submit the full written document.

Senator METZENBAUM. All of the witnesses' entire statements will be included in the record.

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relieves municipalities and their officials "acting in an official capacity" of liability for money damages and attorneys' fees in antitrust actions; only prospective relief can be obtained. The analogy between HIPC's and municipal corporations is close enough to make the LGGA a possible model for the reform legislation to follow. In my view, a right to obtain prospective relief, especially given courts' predictable liberality in granting preliminary injunctions, would provide quite sufficient remedies for providers aggrieved by HIPC abuses. I would suggest, however, that, in the interest of fairness, HIPC's be required to pay the attorneys' fees of successful plaintiffs. Private parties should enjoy comparable immunity in participating in activities initiated or overseen by an HIPC.

Mr. DEVITT. Thank you, Senator. In light of the fact that the Government pays the lion's share of the health care dollar at hospitals like mine, you would think that our national policy would be aimed at making these hospitals more efficient. I have attached an exhibit to my testimony that is a bar chart that shows that over 65 percent of the patient admissions at my hospital are paid for by Medicare or MediCal. This chart shows that there has been a growth in managed care.[1] Obviously, the prices we set have nothing to do with what we get paid by 87 percent of the patients we serve.

Prior to the consolidation of these hospitals, each hospital was operating at an average occupancy of about 25 patients a day. On some days, we had as few as six patients. It is very difficult to spread the fixed costs of operating a hospital and the costs for necessary staffing for nurses and other personnel over such a small volume of patients. Unlike other industries, hospitals cannot easily downsize when patient volume is low and still maintain licensure and accreditation.

We purchased the assets of Ukiah General Hospital for approximately $6 million. That amount is too small to require a Hart-Scott-Rodino filing. Thus, you can imagine how surprised we were when the FTC called on the eve of the closing and indicated they wanted to investigate this transaction.

From the moment the FTC first advised Ukiah Valley on August 10, 1988, that it was going to investigate this transaction, we met with the FTC and asked them to recognize that any combination of two small and financially weak hospitals that resulted in a combined efficient entity was clearly more beneficial than harmful in virtually any setting, but certainly in a rural area such as Ukiah.

Unfortunately, our efforts to persuade the FTC not to proceed were unsuccessful even after an administrative law judge of the FTC ruled that they did not have jurisdiction in our case. We ultimately had a 2-week trial in July of last year in San Francisco. We are gratified that we now have a decision by the chief administrative law judge, Lewis Parker, in our favor which carefully documents the overwhelming evidence showing that this transaction did not injure competition or hurt consumers.

In this regard, the judge's findings are unremarkable to anyone knowledgeable with the health care industry, but being dragged through this process for 4 years has exacted a very high cost, and in light of the FTC's current appeal of the judge's sound decision, it is still not over.

I challenge the FTC to identify for you any negative impact on competition that has occurred as a result of this transaction. They did not offer any admissible evidence to any actual injury to competition at trial. They merely relied on a presumption based on their analysis of concentration. They did not even ask their expert to look at the data reflecting the postacquisition operations and efficiencies.

As it turned out, the trial judge ended up rejecting the FTC's view of the market because he agreed that we compete with three large hospitals in Santa Rosa, CA, which is 60 miles to the south

[1] Due to reproduction problems (four colors) this chart has been retained in committee files.

of Ukiah. A patient origin study shows that 25 percent of the people in our service area that are seeking hospitalization went to these hospitals. In fact, the doctors called as witnesses by the FTC testified that they sent patients there regularly.

Unfortunately, rural hospitals are especially vulnerable to failure. Statistics prove that the trends to fewer admissions and shorter lengths of stay have a disproportionate impact on rural hospitals. In 1988 alone, 43 rural community hospitals closed, and 39 of these had fewer than 100 beds. Significantly, economists of the FTC's Bureau of Economics in a 1991 article discussed the numerous studies which conclude that hospitals with less than 200 beds are inefficient.

The financial situation of Ukiah General Hospital was particularly precarious at the time of the acquisition. Income had declined steadily to a substantial loss for the 9 months ending in June 1988. At the time of acquisition, Ukiah General's balance sheet reflected a negative net worth and a high debt burden and substantial reliance on its parent organization, a for-profit corporation that was already heavily in debt.

Senator METZENBAUM. Why don't you take another minute or so?

Mr. DEVITT. OK, thank you, Senator. We were trying to combine two small hospitals into an efficient operation, and that is what the consolidation was all about in 1988. We had projected that we could eliminate duplicative services and equipment and we would have a cost savings of approximately $3 million in annual savings. We also projected a $2.5 million savings in one-time avoidance of purchases. As it turned out, all of these savings have been realized and, in fact, we have exceeded that amount by $400,000.

Significantly, as of December 3, 1991, Ukiah Valley has saved over $11,100,000 in efficiencies from this acquisition. Our experience demonstrates that significant efficiencies, cost savings and quality of care improvements result from the merger of two small rural hospitals. I am not here to ask that the Congress or the FTC exempt us from FTC laws, but Congress should examine whether the current enforcement of FTC policy, as reflected by the Ukiah prosecution, is appropriate and is in the best interests of the people our antitrust laws and the national health care policy are meant to benefit.

The policy should be to permit the combination of small hospitals, especially when such a combination results in a facility with 100 or fewer acute care beds. We will promote higher quality care for rural America and we will help reduce the Nation's health care bill.

Thank you, Senator.

[The prepared statement of Mr. Devitt follows:]

PREPARED STATEMENT OF VALGENE DEVITT

My name is ValGene Devitt. I am President of Ukiah Valley Medical Center, a not-for-profit hospital located in Ukiah, California. Ukiah is a small rural community of approximately 14,000 people located in Mendocino County, approximately 100 miles north of San Francisco on Highway 101. Ukiah Valley is a 94-bed hospital today.

I am here to tell you about our four and a half year odyssey that started in August of 1988 when Ukiah Valley, then a 43-bed hospital, announced its plan to acquire the assets of Ukiah General Hospital, a 51-bed hospital in Ukiah, California and the FTC decided to investigate and challenge that transaction.

Anyone who has the slightest familiarity with the hospital industry knows that a 50-bed hospital is woefully inefficient. As the economists would say, it is on the wrong side of the cost curve. Most health care professionals are incredulous when I tell them that the federal government has been prosecuting us based on the premise that this acquisition injured competition and might hurt consumers. In my written version of my testimony I have included footnotes that will provide you with articles and studies that show 50-bed hospitals are very inefficient and even potentially dangerous.

In light of the fact that the government pays the lion's share of the health care dollar at hospitals like mine, you would think that our national policy would be aimed at making these hospitals more efficient. I have attached as an exhibit to my testimony a bar chart* that shows that over 65 percent of the patient admissions at my hospital are paid for by Medicare or MediCal. This chart also shows the growth in managed we have experienced.

Prior to the consolidation of these hospitals, each hospital was operating at an average occupancy of about twenty-five patients per day. To have an average of twenty-five patients per day, on some days we had as few as six patients. It does not take a genius to recognize that it is very difficult to spread the fixed costs of operating a hospital and the costs for the necessary staffing of nurses and other personnel over such a small volume of patients. Unlike other industries, hospitals are highly regulated by state and federal regulatory agencies as well as the Joint Commission, and, therefore, they cannot easily downsize even when patient volume is so low if they are to maintain licensure and accreditation.

We purchased the assets of Ukiah General for approximately $6 million. That amount is too small to require a Hart-Scott-Rodino filing. Thus, you can imagine how surprised we were when the FTC called us on the eve of the closing indicating they wanted to investigate this transaction.

From the moment the FTC first advised Ukiah Valley on August 10, 1988 that it was going to conduct a preliminary investigation of the acquisition of the assets of Ukiah General, we met with the FTC and asked them to recognize that given the decreases in inpatient utilization reflected in national trends and specifically the economies of scale facing small hospitals, that it was obvious that any combination of two small and financially weak hospitals that resulted in a combined entity of less than 100 beds was clearly more beneficial than harmful in virtually any setting but certainly in a rural area such as Ukiah. We also asked them to consider our objection to their jurisdiction in light of the fact that the FTC does not have jurisdiction over not-for-profit corporations or assets acquisitions by not-for-profits. Since I am not a lawyer, I will leave the explanation of that legal issue to the footnotes of my written submission.

On August 10, 1988, the FTC issued an extensive request for information. Right away representatives of Ukiah Valley met with the FTC to fully inform the FTC of the reasons this transaction was beneficial to our community. This was the same information, though updated, that was later relied upon in the decision of the FTC's Chief Administrative Law Judge, ruling in our favor at the conclusion of a two week evidentiary trial held this past July in San Francisco. In 1988, the FTC did not seek an injunction against us so we went ahead with the transaction and began the consolidation process. In fact, through September 1988 to the beginning of 1989, Ukiah Valley reported efficiencies to the FTC and provided numerous relevant documents despite our objections to the FTC's jurisdiction.

Prior to the FTC issuing an administrative complaint, Ukiah Valley representatives came to Washington, D.C. and met with each Commissioner and explained the problems plaguing these small Ukiah hospitals. We also presented detailed information on efficiencies, economies of scale and quality of care improvements.

Unfortunately, our efforts to persuade the FTC to address its jurisdiction and problems facing small rural hospitals forthrightly as a threshold matter failed and we have bounced back and forth through various levels of the FTC and the courts for four and a half years. We went through exhaustive discovery and ultimately a two-week trial held in July of last year in San Francisco. We are gratified that we now have a decision in our favor which carefully documents the overwhelming evidence showing this transaction did not injure competition or hurt consumers. The judge found that the transaction benefited consumers and will lead to an improvement in the quality of care. In this regard, the judge's findings are unremarkable to anyone knowledgeable about the hospital industry today. But being dragged through this process for over four years has exacted a very high cost. And, in light of the FTC's current appeal of the judge's sound decision, it still is not over.

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* Due to reproduction problems (four colors) this chart has been retained in committee files.

Our effort to achieve the optimum benefits we anticipated from consolidation have been frustrated by the diversion of significant management attention and resources from the task of providing quality health care. This has hurt us and the Ukiah community we serve. I have no quarrel with the antitrust laws, but it is hard to see how the application of those laws to our transaction has benefited the people we serve or any segment of the public.

As I mentioned, because we were well below the Hart-Scott-Rodino Act threshold, we were not required to wait and because the FTC did not seek an injunction, we went ahead with our closing as scheduled in August of 1988. Thus, we have operated on a consolidated basis for four and a half years. While most merger cases today require enforcement agencies and courts to guess about what the effect on competition might be in the future, we are in the unique position of having an actual track record from the four and a half years of operation. I challenge the FTC to identify for you any negative impact on competition that has occurred because of this transaction. They did not offer any evidence of an actual injury to competition at trial. They merely relied on a presumption based on their analysis of concentration. And since they took the position that concentration was the only issue they waged a battle of experts over the extent of the market. They did not even ask their expert to look at data reflecting the post acquisition operations and efficiencies. I can assure you that when you are only running one emergency room, one pathology lab, one radiology department, one OB unit and so forth for a combined patient population, you are saving some enormous costs.

What is particularly frustrating to a hospital management team of a small not-for-profit hospital is that an agency like the FTC gets so caught up in its own presumptions and procedure that it cannot look at the reality of what has occurred. It cannot admit that our transaction was beneficial for the community because it preserved and improved health care in this community.

As it turned out, the trial judge ended up rejecting the FTC's view of the market because he agreed that we compete with the three larger hospitals in Santa Rosa, 60 miles south of Ukiah. There are three hospitals in Santa Rosa: Santa Rosa Memorial with 225 beds, Kaiser with 110 and Community with 145. The patient origin data showed that 25 percent of the people in our service area seeking hospitalization went to these hospitals. In fact, the doctors called as witnesses by the FTC, testified to sending patients there regularly. And this competition is even more intensive today because two separate new physician groups affiliated with the Santa Rosa hospitals have recently opened offices in Ukiah to see patients. They are directing those patients to Santa Rosa for hospitalization. We had been telling the FTC for over three years that we did not think their view of the market made any sense and we asked to see whatever studies or data they were relying on to support a narrower market. This was not forthcoming and we did not discover their basis until experts were deposed right before trial.

Apparently there is no way that the FTC can re-examine its premise after it gets going on a case and say, Gee, our prediction of negative consequences four or more years ago was off base. Once a complaint is voted, the FTC commissioners then become judges and cannot conmunicate with the staff regarding the progress of a case. So, if the FTC staff were to have misgivings about a case because discovery did not bear out their original theory, that cannot effectively be communicated to the FTC commissioners to precipitate a reconsideration of the wisdom of pursuing the case.

[* * * = The following paragraph may be omitted in my oral presentation]

Let me elaborate very briefly on these issues. First, the jurisdictional issue is probably best left for lawyers to debate. Let me just say that it has been unquestioned for at least twenty-five years that the FTC does not have jurisdiction over not-for-profit corporations.[1] The FTC admits that its jurisdiction under section 4 of the FTC Act does not reach not-for-profits.[2] To challenge an acquisition of assets under section 7 of the Clayton Act, the FTC must first have jurisdiction under its own Act. This construction of section 7 is clear from the Supreme Court's decision in the *Philadelphia National Bank* case.[3]

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[1] *Community Blood Bank of the Kansas City Area, Inc.* v. *FTC*, 405 F.2d 1011 (8th Cir. 1969).

[2] *Hearings before the Subcommittee on Transportation and Hazardous Materials of the House of Representatives Committee on Energy and Commerce.* 101st Cong., 1st Sess. (1989) (statement of William C. McLeod, Director of the FTC's Bureau of Consumer Protection); *see also* Charles A. James, Deputy Assistant Attorney General, Antitrust Division, United States Department of Justice, Remarks before the National Health Lawyers Association (Jan. 31, 1992).

[3] *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 336 and 336 n.11 (1963).

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However, to reach acquisitions by not-for-profit hospitals the FTC has had to resort to a convoluted argument that another section of the Clayton Act is a separate grant of jurisdiction. This novel argument is contrary to the Supreme Court's interpretation of the Clayton Act and the FTC Act as expressly stated in *Philadelphia National Bank*. We pointed this out to the FTC but have found ourselves caught up in a crusade by the FTC to expand its jurisdiction so it can regulate not-for-profit hospitals. Footnoted below you will see the four and a half year chronicle of our attempt to obtain a final ruling on this jurisdictional issue, a trek that has taken us from the Ninth Circuit, to the ruling by Chief Administrative Law Judge Parker agreeing with us that the FTC has no jurisdiction, to the reversal of that decision by the full commission and to a pending appeal in the District of Columbia Circuit.[4]

Let me elaborate briefly on my observations about the competitive effects of this transaction and how the FTC's challenge has affected our ability to deliver high quality health care efficiently in our community.

As this panel is probably well aware, hospitals are closing at unprecedented rates due to rising costs,[5] changes in the form of government reimbursement from cost-

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[4] On August 29, 1988, the FTC wrote one of Ukiah Valley's attorneys, reiterating their request for extensive information without addressing the jurisdictional issue. We responded and again requested that the agency address jurisdiction as a threshold matter.

On September 16, 1988, the FTC claimed jurisdiction under Clayton Act Section 11. On September 30, 1988, our attorneys pointed out that the Section 11 argument had just been expressly rejected in *United States* v. *Carilion Health System*, which held that "The FTC lacks jurisdiction over the defendants because of their non-profit status (*United States* v. *Carilion Health System*, No. 88–0249–R (order granting motion to dismiss) (W.D. Va. Sept. 30, 1988); 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989)).

On February 3, 1989, the FTC issued a subpoena *duces tecum* to AHS/West. This was authorized by a resolution of the full Commission.

In response we filed a petition to quash the subpoena based, in part on lack of jurisdiction under the Clayton Act.

On March 3, 1989, the Commission conducted a hearing on the Petition. And on March 15, 1989, Commissioner Calvani denied our petition (*In re Adventist Health System/West*, 5 Trade Reg. Rep. (CCH) para. 22,658 (March 15, 1989)).

The full Commission affirmed Commissioner Calvani's ruling on April 10, 1989, directing AHS/West to comply with the subpoena by April 21, 1989. We did not comply with the subpoena, because we intended to raise the jurisdictional defense in any federal action attempting to enforce the subpoena. The FTC chose not to try to enforce its subpoena in federal court.

Instead, in August of 1989, the FTC sent Ukiah Valley and AHS/West its draft administrative complaint and advised Ukiah Valley and AHS/West that we would be given an opportunity to be heard prior to the Commission voting on the complaint.

During the weeks of October 2, and October 9, 1989, our representatives personally met separately with Chairman Steiger and each of the other then commissioners. At each meeting, we reiterated the jurisdictional objection and explained the benefits of the transaction.

Despite this effort, the FTC issued its complaint on November 7, 1989. Ukiah Valley initiated an action in federal court to enjoin the FTC (*Ukiah Valley Medical Center* v. *FTC*, 1990–1 Trade Cas. CCH para. 68,916 (N.D. Cal. 1990). The district court, however, ruled that the FTC should first decide the issue. This was appealed to the Ninth Circuit, which affirmed that decision (*Ukiah Valley Medical Center* v. *FTC*, 911 F.2d 261 (9th Cir. 1990)). We then filed a motion to dismiss the administrative complaint before the Administrative Law Judge based on the FTC's lack of jurisdiction over not-for-profits. Now chief administrative law judge, Lewis F. Parker, dismissed the FTC's complaint for lack of jurisdiction and ruled in favor of our position that the FTC lacked jurisdiction (*In re Adventist Health System/West*, No. 92–34, Aug. 2, 1990). On appeal, on August 2, 1991, the full Commission reversed the administrative law judge and remanded for a trial on the merits (*In re Adventist Health System/West*, No. 92–34, Aug. 2, 1991).

Based on our view that the FTC's ruling provided the final agency action on the jurisdictional issue that the Ninth Circuit had thought was missing, we filed a new federal action to enjoin the FTC for lack of jurisdiction, this time in the United States District Court for the District of Columbia. The court denied our request for a preliminary injunction and granted the FTC's motion to transfer the case to the Ninth Circuit. *Ukiah Adventist Hospital* v. *FTC*, 1991–2 Trade Cas. (CCH) para. 69,621 (D.D.C. 1991). On appeal, the United States Court of Appeals for the District of Columbia Circuit affirmed. *Ukiah Adventist Hospital* v. *FTC*, 1992–2 Trade Cas. (CCH) para. 70,078 (D.D. Cir. 1992). A petition for rehearing and suggestion for rehearing *en banc* was filed on February 12, 1993.

There are apparently one or two decisions, depending on how you count, that now support the FTC's view (*FTC* v. *University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991); *United States* v. *Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir.) (*in dicta*), *cert. denied*, 111 S.Ct. 295 (1990)), though at least one final decision, affirmed by the Fourth Circuit support ours (*United States* v. *Carilion Health System*, No. 88–0249–R (order granting motion to dismiss) (W.D. Va. Sept. 30, 1988); 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989)).

[5] *See, e.g.*, Cole and Sizing, *Cole Nurse Compensation Survey*, Modern Healthcare, December 2, 1988, at 24; Wagner, *Weighing the Cost of New Technology*, Modern Healthcare, November 18, 1988, at 43. *See* Freudenheim, *Rising Number of Hospitals Forced to Close*, N.Y. Times, June

based payments to fixed payments per service,[6] and difficulties hospitals confront in spreading their costs due to falling occupancy rates.[7]

At the time we embarked on the acquisition of our 50 bed rival hospital, the number of hospital closures in the country was astonishing. In 1988, eighty-one (81) hospitals closed.[8] From 1980 to 1989, 698 hospitals closed.[9] These trends have continued. Knowledgeable observers predict that 40 percent of all hospitals will be closed or converted to other uses by the year 2000.[10]

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Changes in national health care policy have contributed to the causes leading to the increasing number of hospital closures. In the 1950's, the Hill-Burton Act, 42 U.S.C. section 291 (1982), encouraged the construction of health care facilities. Then, in the 1960's, the Medicare and Medicaid programs enlarged access to health care services. These programs reimbursed hospitals for their costs in providing such health care. Thus, hospitals were encouraged to invest in the construction of expensive facilities with little concern for efficiency.

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These trends pushed health care costs upward. Congress responded to these increased costs by passing the Social Security Amendments of 1983.[11] This legislation provided that hospitals would be reimbursed on the basis of prospectively determined, fixed rates, regardless of the actual costs incurred by hospitals. This program has squeezed overcapacity out of the health care system and forced hospitals, in particular, to become more efficient. Because the reimbursement rates have lagged considerably behind actual increases in costs and because government programs constitute approximately 40 percent of hospital revenues, some hospitals have been forced to shut down.[12]

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Significantly, insurers have also contributed to hospital closures by discouraging admissions to hospitals. Fewer admissions, shorter lengths of stay and the growth of outpatient treatment have exacerbated the problem of excess capacity at many hospitals. For example, the American Hospital Association reported that from 1980 to 1987, admissions per thousand population decreased from 161 to 131 and from 1977 to 1987, average hospital occupancy fell from 7 percent to less than 65 percent.[13] And the growth of outpatient care has also been fueled by advancing technology. What we once considered to be major surgical procedures requiring a three day stay are now routinely handled on an outpatient basis.

The American Hospital Association explained that:

23, 1988, at A17, Col. 1; Office of Evaluation and Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Services, *Why Hospitals Close,* Modern Healthcare, March 24, 1989, at 24.

[6] *See* Touche Ross, U.S. Hospitals: The Future of Health Care—A Survey of U.S. Hospital Executives and Presidents of Medical Staffs on the Challenges They Face in an Environment of Enormous Change, June 1988, at 4; *See also* McCarthy, *DRG's—Five Years Later,* The New Eng. J. of Med., June 23, 1988, at 1683–4. *See* American Hosp. Ass'n, *Hospital Statistics—Data from the American Hospital Association 1988 Annual Survey,* 1988, at XXV; Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System: Report to the Congress,* 1990, at 52.

[7] *See* Touche Ross, U.S. Hospitals: The Future of Health Care—A Survey of U.S. Hospital Executives and Presidents of Medical Staffs on the Challenges They Face in an Environment of Enormous Change, June 1988, at 4; *See also* Bureau of the Census, U.S. Dep't of Commerce, *Statistical Abstract of the U.S. 1989,* 1989, at 102.

[8] Burda, *Why Hospitals Close,* Modern Healthcare (March 24, 1989) at 24.

[9] American Hospital Ass'n., *Hospital Closures 1980–1989: A Statistical Profile* at 6 (March 1990).

[10] *See* Hackbarth, Jones, Moran and Rubin, A Report by Lewin/ICF, A Division of Health Care and Sciences Research, Inc., to the National Committee for Quality Health Care, Washington, D.C., *Critical Condition, America's Health Care in Jeopardy* (1988) at 13.

[11] 42 U.S.C. sec. 1395w (1982), as amended by Social Security Amendments of 1983 Pub. L. No. 98, Title VI, sec. 601.

[12] *See* Campbell and Teevans, *Mixed Signals: Recent Cases Make the Legality of Future Hospital Mergers Less Predictable,* 59 ABA Antitrust L.J. 1005, 1009–12 (1991); Brief of American Hospital Association as Amicus Curiae in Support of Petition for Writ of Certiorari at 3–7, *United States* v. *Rockford Memorial Corp.,* No. 90–162.

[13] American Hospital Ass'n., Hospital Statistics 1988 at xxvi, xxxii–iii.

> [t]hese cost-containment measures have led to a decline in both admissions to hospitals and the length of hospital stays * * * Outpatient visits to hospitals have increased by 160 percent since 1980; indeed, according to the latest data, since 1986 outpatient visits have exceeded inpatient days. Almost half of all surgical procedures are now outpatient procedures, and growth in outpatient revenues far outstrips growth in inpatient revenues.[14]

Unfortunately, small rural hospitals are especially vulnerable to failure under these conditions. Statistics prove that these trends have a disproportionate impact on small, rural hospitals. Between 1980 and 1988, of the 445 community hospitals closed, 206 were rural hospitals; and from 1986 to 1988, the number of rural hospital closures outnumbered urban hospital closures. In 1988 alone, 43 rural community hospitals closed, and 39 of these had fewer than 100 beds.[15] Forty-four rural community hospitals closed in 1989.[16]

Small rural hospitals are especially vulnerable because they are terribly inefficient. They cannot spread their fixed costs over a high enough volume of patients. As long ago as 1967, prominent study found that as hospital size increases, average cost declines until reaching an average daily census of approximately 190 patients.[17] This study found that even for hospitals in the simplest service category group, minimum average cost was not achieved until average census reached 60 patients per day.[18] These findings are unsurprising and have been validated again and again.[19]

Significantly, economists in the FTC's Bureau of Economics in a 1991 article recently discussed the numerous studies which conclude that hospitals with less than 200 beds are inefficient:

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> A recent review of the literature on hospital cost function estimation [footnote omitted] found that most analyses characterize production of hospital services as having constant returns to scale or constant unit cost with increasing output once a threshold of approximately 200 beds is reached. [footnote omitted] Thus, most of these studies indicate that hospitals below this size prior to the acquisition are not capable of producing hospital services with maximum efficiency.[20]

These economic facts of life make everyone in the health care industry question the appropriateness of the Ukiah prosecution.

Prior to August 1988, Ukiah had three, very small, acute care general hospitals—Ukiah Adventist Hospital, Ukiah General Hospital, and Mendocino Community Hospital. Respectively, they had 43 beds, 51 beds and 56 beds. In addition to the economies of scale problems facing these very small hospitals, they each suffered from extremely low occupancy rates. When hospitals like these are operating at a 50 percent occupancy rate and sometimes have only six patients in them, they are financially weak and are particularly vulnerable to being hit with a financial disaster such as incurring one Medicare outlier. (A Medicare outlier is a Medicare patient whose treatment greatly exceeds the DRG reimbursement schedule. Even after receiving whatever extra reimbursement is available, the hospital absorbs significant extraordinary costs.)

The financial situation of Ukiah General was particularly precarious at the time of the acquisition. Income had been declining steadily to a breakeven position in 1987 and to a substantial loss for the nine months ending June 30, 1988. At the time of acquisition, Ukiah General's balance sheet reflected a negative net worth, a high debt burden, and substantial reliance on its parent organization, a for-profit corporation that was already heavily in debt. Irrespective of whether the technical requirements of a failing company defense could be met here, as the FTC applies that doctrine, no one could dispute the fact that hospitals are an industry in de-

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[14] Brief of American Hosp. Ass'n as Amicus Curiae, *supra* at 5–6.

[15] Hospital Data Center, American Hospital Association, *Hospital Closures 1980–1988: A Statistical Profile*, 1989, at 5.

[16] American Hospital Ass'n, Hospital Closures 1980–89: A Statistical Profile at 24 (March 1990).

[17] Carr & Feldstein, *The Relationship of Cost to Hospital Size*, 2 Inquiry 60 (March 1967).

[18] *See also* Blackstone & Fuhr, *Hospital Mergers and Antitrust: An Economic Analysis*, 14 J. Health Pol., Pol'y & L. 383, 383 (1989); Christianson & Finch, *Rural Hospital Costs: An Analysis with Policy Implications*, Public Health Reports at 423–33 (1981).

[19] Ira Moscovice & Roger A. Rosenblatt, *A Prognosis for the Rural Hospital*, J. of Rural Health, Part II, July 1985, at 13.

[20] Vita, Langenfeld, Miller, and Pautler, *Economic Analysis in Health Care Antitrust*, 7. J. Contemp. Health L. & Pol'y 73, 97–8 (1991).

cline.[21] Given the trends in closures of small, rural hospitals, Ukiah General's closure was a distinct possibility.

Though I am not an antitrust expert, I would point out that Robert Pitofsky in his critique of current merger enforcement policy in the December issue of the Georgetown Law Journal points out the need to have a more lenient enforcement policy with respect to distressed industries. He said, "Indeed, prominent economists have pointed out that the *strongest* case for permitting mergers in order to achieve efficiency arises with respect to failing firms and distressed industries.[22] The theory as to why financially weak firms with chronic overcapacity would seek to merge with rivals that have the same problem is that they can raise capacity utilization, mesh complementary assets, drop the weaker elements of each organization and develop the strengths of each.

This is what we were doing when we decided that rather than withdraw from Ukiah we would address our efficiency and quality concerns by combining with Ukiah General Hospital. Efficiency considerations were a key to Ukiah Adventist's decision to acquire Ukiah General. The consolidation of Ukiah Adventist and Ukiah General, with 43 and 51 beds respectively, resulted in a 94-bed hospital which better approximated the size at which economies of scale could begin to be achieved. We moved from 50 percent capacity utilization to 60 percent.

Prior to the acquisition, we projected that we could eliminate duplicative clinical services, administrative functions, and related overhead expenses to achieve a cost savings of approximately $3 million in annual, ongoing savings. The elimination of duplicative obstetrical related services alone was expected to effect a savings of $500,000. The most significant short-run savings opportunity resulting from the merger, however, was expected to be the elimination of over $1.7 million in overlapping and duplicative staffing costs. These are costs that would otherwise have to be paid by our patients.

A $2.5 million one-time cost savings was also anticipated. The largest one-time cost savings was the cancellation of plans to construct and equip a new Birthing Center at Ukiah Adventist that would have duplicated facilities at Ukiah General. We also anticipated $400,000 in savings from the sale of duplicative equipnent.

As it turns out, all these savings were achieved. Indeed, the savings even surpassed those expectations. Ongoing annual cost savings exceeded original projections by almost $400,000.

Significantly, as of December 3, 1991, Ukiah Valley saved over $11,100,000 in efficiencies as a result of the acquisition.

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Numerous Ukiah physicians, government officials, third party payors, and commercial executives endorsed the acquisition, realizing the enormous efficiencies which could be achieved. Obviously when you previously had two radiology services and after the consolidation you only have one, you could have at least one physician who perceives himself disadvantaged by the transaction. But the overwhelming weight of the physician testimony at trial was in favor of this transaction and the improvements it created. This included physicians who would no longer be the exclusive provider of emergency or pathology services at one of the hospitals.

Economic efficiency has the added benefit of freeing revenues, facilitating the redirection of savings toward improving the quality or health care provided in Ukiah. By October 1989, Ukiah Valley achieved a substantial improvement in the quality of care offered to the citizens of Ukiah, and additional quality improvements have been made since then. The two emergency departments were consolidated on one site. This combined the staff, resources and backup in one department to serve 2,000 visits per month. This consolidation provided an improved operation and service over running of two departments with only 700 to 800 visits each.

The Ukiah Valley consolidated emergency room attracted more highly qualified physicians and nurses. Prior to the acquisition, Ukiah General had only one full-time emergency room physician and two part-time practitioners. Ukiah Adventist then had only four full-tine emergency room physicians, only two who were board certified. Since the acquisition, Ukiah Valley now has eight full-time emergency room physicians, all of whom are now board certified. The acquisition has also increased the number of certified emergency nurses in the Ukiah community.

This has directly improved the quality of care in our community. If I was ever in an accident on Highway 101 in Ukiah, I would rather be treated in the new emer-

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[21] *See,* Pitofsky, *Proposals for Revised United States Merger Enforcement in a Global Economy,* 81 Georgetown L.J. 195 at 227–240 (1992).

[22] *Id.* at 238.

gency room rather than the small, inefficient and less proficient facilities that existed before.

Combined facilities permitted the developent of a locally based blood banking and collection service, resulting in the provision of 75 percent of their needs in our hospital; prior to the acquisition, this figure was only 25 percent so that the hospital had to rely on blood from blood banks in other geographic areas. The expanded blood bank collection services reduced the per unit price of blood by approximately 10 percent, and the combined hospital realized significant savings in nursing personnel. The hospital has now installed specialized nuclear medicine scanning equipment, whereas neither hospital had that service prior to the acquisition. C.T. scans were provided in-house rather than using a lower quality non-hospital unit.

Our experience is indicative of the experiences of other small hospitals that have merged. Studies constantly demonstrate a positive correlation between hospital size and quality of care. An increase in volume enhances staff proficiency.[23] The pooling of patient care volumes in the emergency room lead to improvements in staff proficiency. Avoiding duplicative birthing centers allows physicians to handle all procedures at one location and, concomitantly, to refine their skills.

Our advances in efficiency and quality of care in Ukiah continue to the present. Increased volume facilitates improvements in case management and related decreases in the average length of stay, resulting in medical cost savings for the Ukiah community. Because of the improvement of quality of the emergency physician staff, malpractice premiums decrease. The kitchen, cooking, accounting, admitting, linen and housekeeping, record keeping, data processing, and personnel departments report additional staff efficiencies. These cost savings enable Ukiah Valley to broaden the services provided to indigent patients, resulting in more complete provision of services to the community. Furthermore, prior to the consolidation, without OB the hospital could not accommodate most managed care contracts; now, Ukiah Valley serves several managed care contractors, inclucding HMO's.

The FTC's prosecution is premised on the presumption that an injury to competition will occur. But we now have over four years of operating history which demonstrates no such injury has occurred. Our price increases have been far less than the average of other California hospitals. We now have more managed care contracts than before. Managed care providers and insurers have all told the FTC that they get competitive prices from us and that they recognize we have improved quality and efficiency.

Of course, what is particularly tragic is that investigations like this result in great expense not only for the hospital but also for the community it serves. The protracted hearing on the merits against a very small, not-for-profit hospital is causing grave harm. To date, Ukiah Valley has been forced to expend over a $1.7 million defending this transaction and trying to fend off an attack which serves no valid public purpose. Recently, because of the attention the *Ukiah* case has received in industry publications, an FTC spokesman tried to suggest that the hospital's legal strategy was a cause of the protracted nature of the proceeding. This is nonsense. Also attached to my testimony is the letter Don Ammon, chairman of our hospital's board to *Modern Healthcare,* a leading industry publication, explaining why that charge is baseless. Beyond actual expenditures, a drawn out battle with the FTC forces Ukiah Valley to divert scarce financial resources it might otherwise spend on staff salaries and health care services. Ukiah Valley's staff is paid less than other area hospitals, and Ukiah Valley has also had to defer making major necessary equipment purchases, such as diagnostic x-ray equipment, until after this matter is resolved. The uncertainty of this matter has also harmed Ukiah Valley's ability to secure financial support and its ability to recruit medical personnel.

At the same time, the trends in the health care industry that provided the original rationale for the acquisition show little signs of relenting. Although the rate of hospital closures slowed slightly during 1989 and 1990, community hospitals with fewer than 100 beds account for 74 percent of hospital closings in those years.[24] Closures of rural community hospitals continue to surpass closures of urban community

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[23] Hannan, O'Donnel, Kilburn, Bernard and Yazici, *Investigation of the Relationship Between Volume and Mortality for Surgical Procedures Performed in New York State Hospitals,* 262 J. Am. Med. Ass. 503 (July 28, 1989); Hughes, Hunt, Luft, *Effects of Surgeon Volume and Hospital Volume on Quality of Care in Hospitals,* 25 Med. Care 489 (June 1987); Harold S. Luft, *The Relation Between Surgical Volume and Mortality: An Exploration of Causal Factors and Alternative Models,* 23 Med. Care 940 (Sept. 1980).

[24] Hospital Data Center, American Hosp. Ass'n, *Hospital Closures 1980–1990: A Statistical Profile,* February, 1991, at 11; Cleverly, *Larger Urban Hospitals Increasingly on Closed List, Healthcare Financial Management,* Sept. 1991, at 77.

hospitals,[25] and in 1990 California had the second largest number of community hospital closures in the country.[26] The AHA statistics for 1991 show 45 hospitals closed last year, two thirds of them in rural areas.[27]

While we might not have met all of our goals, the cost savings, increased efficiency, and enhancement of the quality of care that have resulted from the consolidation, provide a bright contrast to the rather bleak backdrop of the current state of the health care industry. Our achievements are especially remarkable given the financial burden and the accompanying constraints of the relentless FTC investigation.

Our experience clearly demonstrates the efficiencies, cost savings, and quality of care improvements that emanate from the merger of two small, rural hospitals. I am not here to ask that Congress or the FTC exempt us from the antitrust laws. But we think Congress should examine whether current enforcement policy as revealed by the *Ukiah* prosecution is appropriate and in the best interests of the people our antitrust laws and our national health policy are meant to benefit. The policy should be to permit the combination of small hospitals, especially when such a combination results in a facility with 100 or fewer acute care beds. This will promote higher quality health care for rural America and will help reduce the nation's health care bill.

Senator METZENBAUM. Thank you very much, Mr. Devitt, and you make a persuasive case with respect to your argument as to it is not only the law, but it is a question of how you enforce the law.

Mr. Rothschild, we are very happy to have you with us.

STATEMENT OF VERNON R. ROTHSCHILD

Mr. ROTHSCHILD. Thank you, Senator. Mr. Chairman and members of the subcommittee, thank you for allowing me to tell my story and I hope it is of help to you in the decisions you must make.

In the broadest outline, the situation is this. The largest hospital company in the Washington, DC, area, Medlantic, has created its own captive prosthetic company through a joint ownership arrangement with a prosthetic provider.

Senator METZENBAUM. Would you bring the mike a little closer to you, please?

Mr. ROTHSCHILD. The joint arrangement has managed to channel most new prosthetic candidates in the District area directly to it, eliminating a meaningful opportunity for other prosthetic companies to compete to serve those patients. The patients and our health care system are suffering the inevitable consequences of this foreclosed competition—inferior selection and quality and increased costs.

For me, the story began in 1963 when I was involved in an automobile accident resulting in the loss of my left leg below the knee. In 1965, I entered a training program at the Veterans Administration's prosthetic center in New York City to learn prosthetics, the art of replacing a missing member with a prosthesis or artificial arm or leg, and orthopedics, the art of bracing a weakened member of the body with a brace.

In 1977, I opened my own practice and company in Washington, Rothschild's Orthopedics. Over time, as we gained the confidence of the area's doctors and hospitals, we built a thriving small business.

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[25] Hospital Data Center, American Hosp. Ass'n, *Hospital Closures 1980–1990: A Statistical Profile,* February, 1991, at 7.

[26] Hospital Data Center, American Hospital Association, *Hospital Closures 1980–1990: A Statistical Profile,* February, 1991, at 13.

[27] Modern Healthcare, June 15, 1992 at 2.

The key was the prosthetics clinics held within each area hospital before the patient was discharged.

At each of the clinics, two, three, or even four of the area's competing prosthetic companies would be present to examine the amputee patient and discuss with the patient's physician and physical therapist the best prosthesis for the patient. The doctor and therapist would guide the ultimate choice. The prosthetic companies needed to be very competitive in terms of service, quality, and price or, over time, the doctors or hospitals would cease recommending them. Our practice doubled almost every year until 1986, the year that Medlantic began its expansion into the prosthesis business and the exclusion of competitors.

In 1986, Medlantic opened the National Rehabilitation Hospital, NRH. As I have indicated, NRH formed its own prosthetic company through a joint venture. In addition to channeling NRH's own patients to its captive provider, Medlantic also essentially closed a prosthetic clinic at Washington Hospital Center, which it also owns, and channeled those patients to the NRH in-house provider.

Since the Washington Hospital Center had been one of our main sources of business, this was very bad news, but what followed was even worse. The prosthetic clinics began closing or radically shrinking one by one at the other hospitals in the city. These hospitals were instead transferring their amputees after their amputations to NRH and they were then channeled directly to the in-house captive prosthetic provider.

Let me be clear; we and the other few independent prosthetic companies are foreclosed from these patients. We are not allowed on the premises. Instead of a system where health care professionals consult with and choose between several independent competing providers, these doctors and therapists are now part of a closed process at which only the captive provider is present.

Poor work by the prosthetic provider cannot be punished by steering business from it. There is no check on it or disincentive to the selection of an unnecessarily costly prosthesis, or of too many temporary prostheses or of charging too much for a prosthesis. Patients do not even learn of patented exclusive products not available from the captive provider.

As the non-NRH amputee clinics began to close or dwindle, Rothschild's Orthopedics began to experience severe financial trouble. I cashed in life insurance policies and sold my home, with the money being used to keep us afloat and to develop new markets in Baltimore, Delaware, and Maryland's Eastern Shore where we now have our main office, in Salisbury, MD.

If the present situation continues, we will have to close our offices in the Washington area. The predicament of the other prosthetic companies in Washington is probably just as bleak. Medlantic has excluded us from any chance to compete for the vast majority of new patients in the area. The friendly and constructive competition that existed prior to Medlantic's scheme was magnificent on the patient's behalf. Costs and results were easily monitored by the physician. Conversely, today at the National Rehabilitation Hospital the patient is presented with one choice, one hospital, and one prosthetic company, all owned by the hospital.

Is this foreclose of competition legal? We have consulted attorneys who believe it is an antitrust violation. They told me similar practices harmful to patients have recently been struck down by the courts. We have asked the FTC to investigation this situation. We could also take our case to court. The attorneys tell us that if Medlantic's joint venture and related activities, on balance, are harmful to consumers, it is illegal. They say that if the FTC or court determines that it is harmful to consumers, the practice can be stopped and we can again have a chance to pursue our livelihood in Washington and patients in this area can again have the benefits of competition. Isn't this as it should be? It seems to me that any change in the law that makes practices like this difficult to challenge would be to wrap an injustice in an additional injustice.

Thank you, and once again I would be happy to attempt to answer any questions you might have.

Senator METZENBAUM. I think you make a very persuasive case, Mr. Rothschild. I don't know what the hospital's answer is. I am going to ask my staff to make an appropriate inquiry both of the FTC and the Antitrust Division. I don't think you should have to go to a private lawsuit. It seems to me that you are only asking for an opportunity to compete in the free enterprise system and you are being foreclosed by the hospital. We will inquire into it, and I am quite persuaded.

Mr. ROTHSCHILD. Thank you, Senator.

Senator METZENBAUM. Our last witness on this panel is the Honorable Reginald Matthews, speaking on behalf of the AARP. Mr. Matthews is from Sugar Land, TX. We are happy to welcome you, sir.

STATEMENT OF REGINALD S. MATTHEWS

Mr. MATTHEWS. Good morning, Mr. Chairman and Senators. My name is Reginald Matthews. I am the regional coordinator for AARP/VOTE from Sugar Land, TX. AARP commends the subcommittee for holding this hearing to focus on the role of the Federal antitrust laws in a reformed health care system. As a membership organization of Americans 50 years of age or over, we are here to bring the perspective of health care consumers to this discussion.

To begin with, the——

Senator THURMOND. If you don't mind, speak into your microphone so we can hear you better.

Senator METZENBAUM. Bring it a little closer to you.

Mr. MATTHEWS. Thank you very much. To begin with, the case for health care reform is compelling. Increases in the costs of health care in the United States have become uncontrollable. The growing cost of health care is expected to continue in the absence of reform that incorporates effective cost containment.

Comprehensive health care reform is AARP's top legislative priority. We are heartened by the President's commitment to comprehensive health care reform and we look forward to learning more about his approach. Although there has been much discussion about the President's concept of managed competition, at this stage no one knows precisely what shape the proposed reforms will take. We view our testimony today as part of a continuing dialog on

health care reform and look forward to continuing to assist this subcommittee in its deliberations on health care reform.

Our written testimony addresses the specific proposals of the American Medical Association, the American Hospital Association, and the Pharmaceutical Manufacturers Association. I will make some general points applicable to all proposals in this statement, but I will refer you to our written statement for a more detailed discussion.

The positions of the provider associations appear to be based on a belief that antitrust enforcement is a barrier to the development of new forms of health care delivery. It is argued that health care markets are different from other markets and that this difference makes the competition theories that underlie antitrust laws inapplicable to health care markets.

AARP believes that competition promoted by the antitrust laws has a role to play in fostering innovation and keeping down health care costs. Indeed, had it not been for enforcement of the antitrust laws, many of the existing innovations of health care delivery that have benefited consumers could not have occurred.

For example, antitrust enforcement was necessary to overcome resistance to innovative forms of practice such as health maintenance organizations, to cost containment efforts by purchasers of health care services, and to providing consumers with information about price, quality and services provided.

While AARP applauds the willingness of provide organizations to work toward controlling health care costs, we remain skeptical that the approach advocated before this subcommittee, a relaxation of antitrust enforcement, will produce benefits to consumers. The provider associations propose replacing policies that have been the driving force for innovations in health care markets with self-regulatory approaches that have been discredited time and time again.

AARP believes that a relaxation of antitrust laws may result in health care markets that are less responsible to patient needs by permitting activities that will lead to higher prices and restricted consumer choice. Nor is there a need for such a drastic remedy. AARP believes that the proponents overstate the limits that antitrust enforcement imposes upon the ability of their members to engage in generally beneficial collaborative activity.

To the extent that providers are seeking to engage in procompetitive collaboration, we believe that history has shown that antitrust laws are flexible. Therefore, activity that is demonstrably proconsumer would be exempt from the law because it would not violate the law.

I thank the committee very much for permitting us to be here. I would be most happy to attempt to answer such questions as you may have. Thank you very much.

[The prepared statement of Mr. Matthews follows:]

PREPARED STATEMENT OF REGINALD S. MATTHEWS ON BEHALF OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Good morning. My name is Reginald S. Matthews and I am Regional Coordinator for AARP VOTE from Sugar Land, Texas. AARP commends the subcommittee for holding this hearing to focus on the role of the federal antitrust laws in a reformed health care system. As a membership organization of Americans 50 years of age and

over, we are here to bring the perspective of health care consumers to this discussion.

THE URGENT NEED FOR COMPREHENSIVE HEALTH CARE REFORM

The case for health care reform is compelling. For more than a decade, increases in the costs of health care in the United States have been uncontrollable. Health expenditures consumed 7.4 percent of the Gross Domestic Product (GDP) in 1970; they exceeded 13 percent of GDP in 1991; and they are projected to reach 18 percent of GDP by the year 2000. The growing cost of health care in this country is expected to continue unabated in the absence of comprehensive health care reform that incorporates effective cost containment.

Escalating costs affect every segment of the population and limit access to coverage and services. They also affect our economy's health, our competitiveness, and the health of tens of thousands of businesses, large and small. By 1992, the estimated number of individuals without health care insurance rose to 36 million. The public demands change. Opinion polls indicate that almost 80 percent of Americans feel their health care costs are too high, and almost 90 percent believe their health care system needs to be completely restructured.

Comprehensive health care reform is AARP's top legislative priority. For the past three years, AARP has explored with our members and the American people the need for reform of our health care system and possible solutions to that end. At the same time, we have waged a vigorous campaign, nationally and at the grassroots level, to make health care reform, including long-term care, a vital issue in the Presidential and Congressional elections.

As part of the dialogue with our members, the Association outlined its vision of how to reform health care, called *Health Care America*. Ours is an ambitious and comprehensive proposal which guarantees universal access to quality health and long-term care, system-wide cost containment, prescription drugs, and fair and affordable financing. *Health Care America* is based on AARP's principles for health and long term care reform, which we have attached to our testimony.

We are heartened by the President's commitment to comprehensive health care reform, and we look forward to learning more about his approach. Although there has been much discussion about the President's concept of "managed competition," at this stage, no one knows precisely what shape proposed reforms will take. The Association, however, believes it shares the same goals with the President: universal access to health and long-term care services; fair and equitable financing; and effective cost containment. We recognize that there are many paths to the same goal and have been engaged in a dialogue with a broad spectrum of participants in the health care debate. We view our testimony today as a continuation of that dialogue and look forward to continuing to assist this subcommittee in its deliberations on health care reform.

THE ROLE OF THE ANTITRUST LAWS IN HEALTH CARE

Our testimony will assess current antitrust enforcement from the perspective of the health care consumer. We will address the proposals of the American Medical Association (AMA), the American Hospital Association (AHA) and the Pharmaceutical Manufacturers Association (PMA) to the extent possible, given the uncertainty about the specific structure of reform.

Initially, we observe that the positions of the provider associations appear to be based on a belief that antitrust enforcement is a barrier to developing new forms of health care delivery. It is argued that because insurance and other third party payment programs diminish the role of price in consumer decision-making and because consumers lack information necessary to make health care decisions, health care markets are different than other markets and that this difference makes the competition theories that underlie the antitrust laws inapplicable to health care markets.

Health care does not lend itself to the traditional supply-demand models. Nonetheless, AARP believes that competition promoted by the antitrust laws has a role to play in fostering innovation and keeping down health care costs. Indeed, had it not been for enforcement of the antitrust laws, many of the existing innovations in health care delivery that have benefitted consumers could not have occurred. AARP has been an advocate for many of these "competition"-based reforms. For example, AARP strongly supported the efforts of the Federal Trade Commission to increase competition in the market for ophthalmic goods and services by actively participating in the Commission's "Eyeglasses I" and "Eyeglasses II" Rulemaking proceedings. The Association opposed a merger of the two dominant manufacturers of wheelchair and stair-way lifts, items of durable medical equipment used primarily by disabled

older persons.[1] AARP has supported the availability of health maintenance organizations and other alternative forms of health care delivery.

While AARP applauds the willingness of organizations such as the AMA, the AHA, and the PMA to seek innovative approaches to controlling health care costs, we remain profoundly skeptical that the approach advocated before this subcommittee, a relaxation of antitrust enforcement, will produce benefits to consumers. The AMA, the AHA, and the PMA propose replacing policies that have been a driving force for innovation in health care markets with self-regulatory approaches that have been discredited time and again. To justify eroding the benefits provided by the antitrust laws, the AMA, the AHA, and the PMA have a heavy burden of proof. They have failed to meet their burden.

Any relaxation of antitrust enforcement while fundamental reform of the entire health care system is under consideration would be premature at best, and at worst, could undercut the effectiveness of reform and harm consumers. Nor is there a need for such a drastic remedy. To the extent that providers are seeking to engage in pro-competitive collaboration, we believe history has shown that the antitrust laws are flexible and their application is highly fact-specific. Therefore, activity that is demonstrably pro-consumer need not be exempt from the law, because it will not violate the law.

ANALYSIS OF PARTICULAR PROPOSALS

The American Medical Association (AMA) proposal

The AMA contends that, in order for health care reform to succeed, physicians must be able to act collectively on issues relating to the delivery of and payment for care. The AMA contends that its proposals are necessary in order that physicians be able to exercise countervailing power to what the AMA perceives as the market power of third party payers and other purchasers. The AMA believes that collective efforts by physicians are necessary to protect the interests of patients from inappropriate action by payers.[2]

Specifically, the AMA seeks exemption from antitrust liability for physicians: (1) who collectively agree on reimbursement levels to propose to a payer; (2) who form joint marketing ventures to negotiate contracts with employers and other purchasers of medical services, whether or not the physicians share direct financial risk; (3) who form negotiating groups to bargain collectively with payers; and (4) who are affiliated with a managed care plan to collectively negotiate with the plan concerning coverage decisions, quality assurance matters, and administrative and reimbursement issues. The AMA seeks to have its proposals implemented either through a change in enforcement policy or through adoption of legislation.

In evaluating the AMA proposals, the subcommittee should bear in mind that the history of collaborative efforts by physicians has been a history of opposition to innovative forms of practice that have expanded consumer choice and increased access to care. When the concept of physician group practice (a precursor to today's health maintenance organization) was in its infancy, the AMA and the Medical Society of the District of Columbia attempted to interfere with the operations of Group Health Association, an early type of health maintenance organization, by taking actions against its physicians and against physicians and hospitals who worked with its staff. These actions included efforts to exclude the Group Health Association physicians from hospital facilities and malpractice insurance. These activities ultimately resulted in a criminal conviction that was upheld by the Supreme Court in 1943.[3]

Until the Federal Trade Commission took action in the mid-1970's, the AMA's ethical standards prohibited physicians from entering into contracts with managed care plans, from competing on price, and from truthfully advertising information about price, quality, or services provided.[4] The AMA's "ethical standards" served as a barrier to innovative forms of practice and hindered the ability of consumers to choose among providers.[5]

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[1] In the Matter of American Stair-glide Corporation, et al. FTC Docket No. C-3331, (Consent Order May 17, 1991).

[2] We use the term "payer" to refer not only to insurance companies, but to all large purchasers of health care services: employers, health care plans (HMO's, PPO's, etc), including the proposed Health Insurance Purchasing Cooperatives ("HIPC's").

[3] *American Medical Association* v. *United States*, 317 U.S. 519 (1943).

[4] *American Medical Ass'n*, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982).

[5] *Id.*, 94 F.T.C. at 1005. *See also*, The Bureau of Economics Staff Report on Effects of Restrictions on Advertising and Commercial Practice In The Professions: The Case of Optometry, (September 1980) (concluding that restrictions on advertising and commercial raise costs to consumers without improving quality).

The AMA has failed to make a persuasive case that payers possess such power as to create an "uneven playing field" or that they exercise such power as they may possess in a manner contrary to the interests of health care consumers. In fact, it could be argued that to date payers have had only modest influence on the prices charged by providers (and that only in recent years as health care costs have skyrocketed). Many analyses have concluded that this lack of purchasing power on the part of payers has fueled health care cost increases. Indeed, it has been the payers' search for price competitive providers that has driven the development of innovation.

AARP does not share AMA's belief that payers exert a harmful influence in the market for health care goods and services. To the contrary, AARP views the evolution of alternative delivery service programs as a positive development that has expanded access to care and resulted, at least in some instances, in lower health care prices. While third party payers could have the power to engage in actions that might be detrimental to consumers, the AMA has not established that collective action by physicians is the indicated remedy.

If an exemption were to be granted, it is not clear that physicians acting collectively will act in the interest of consumers. The record of physician involvement with the insurance industry ought to give the subcommittee pause before adopting any proposed exemption. A Federal Trade Commission study of provider control of Blue Shield plans reported evidence that control of plans had been used to increase physician's fees and to resist competition from other providers and plans.[6]

There is an extensive record of medical providers using boycotts to obstruct operation of cost-containment programs developed in response to payer demands for lower prices.[7] For example, in *Michigan State Medical Society,* the Federal Trade Commission found that a medical society orchestrated a campaign under which its members collectively threatened to withdraw from Medicaid and third-party payer programs unless these payers adopted higher reimbursement rates.

That providers cannot always be relied upon to act with the consumer in mind is further evidenced in the recent case in which 30 Tucson dentists successfully demanded that prepaid dental plans institute identical increases in copayments—direct out-of-pocket consumer costs.[8]

Clearly, the interests of consumers and health care providers are not always as coincident as the AMA would suggest. Efforts by practitioners to raise prices and obstruct cost containment programs demonstrate a disregard for the interests of consumers and a desire "to pre-empt the working of the market by deciding for itself that consumers do not need that which they demand".[9]

The AMA has raised the specter that *payers* may also operate contrary to consumer interests by engaging in actions that may impede access or quality. We do not dispute the potential for this eventuality, nor that in some cases, it can be found to have occurred. However, there are vehicles other than collective action by physicians for curbing any actions by a payer detrimental to patient interest—vehicles that do not require exemption from the antitrust laws.

For example, grievance and appeals mechanisms exist for plan members to remedy concerns about access to services. External oversight is the appropriate remedy to ensure that interests in quality and access are not overpowered by interests in reducing costs. Ultimately, a consumer dissatisfied with a health plan should be able to choose another plan, so that competition among plans should improve access and quality. From the standpoint of the consumer, an antitrust exemption would increase the risk of harmful collaborative physician activity.

Furthermore, the information provided by AMA does not demonstrate that existing antitrust laws and enforcement policies are actually preventing legitimate collaborative efforts by physicians to improve patient care. For example, the Department of Justice reports that it favorably reviewed a proposal under which an accounting firm would collect and evaluate the average charges of physicians belonging to a preferred provider organization that performs kidney and liver transplants so that the organization could better evaluate fee proposals from purchasers.[10] In-

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[6] Medical Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans, Staff Report to the Federal Trade Commission (1979).

[7] *Federal Trade Commission* v. *Indiana Federation of Dentists,* 476 U.S. 447 (1986); *Michigan State Medical Society,* 101 F.T.C. 191 (1983); *Southbank IPA, Inc.,* C–3355, 57 Fed. Reg. 2913 (1992) (consent order).

[8] *United States* v. *Alston,* 974 F. 2d 1206 (9th Cir. 1991).

[9] *Indiana Federation of Dentists, supra,* 476 U.S. at 462.

[10] Remarks of Robert E. Bloch, Chief, Professions and Intellectual Property Section, Antitrust Division, U.S. Department of Justice, Before The National Health Lawyers Association (February 19, 1993) at 7.

deed, much of the conduct that has been challenged by the Commission and the Department of Justice appears to involve the types of concerted action by providers that even the AMA concedes ought to be prohibited, such as group boycotts. In AARP's judgment, the risks associated with the AMA proposal far outweigh any potential benefits to consumers.

THE AMERICAN HOSPITAL ASSOCIATION (AHA) PROPOSAL

In various forums, the AHA has argued that antitrust enforcement policy is having a chilling effect upon mergers and other collaborative activities that are necessary in order to reduce excess hospital capacity and an irrational proliferation of medical services or equipment. AARP agrees that a more rational policy with respect to health care spending and distribution of resources could encourage greater innovation, cost-effectiveness, and access to health care. However, although AARP and AHA share, to some extent, similar goals, insulating hospitals from the antitrust laws is neither sound policy nor supported by the evidence.

As a preliminary matter, the evidence simply does not support the argument that hospitals are being deterred from undertaking beneficial collaborative efforts because of a chilling effect of antitrust enforcement. An examination of the data concerning hospital mergers shows a period of active consolidation in the hospital industry. According to the Department of Health and Human Services (HHS), 229 mergers took place from 1987 to 1991. The Federal Trade Commission and Department of Justice investigated only 27 of the mergers. Of these, 19 were approved, 3 were abandoned by the parties, and only 5 were challenged in court.[11] These data hardly indicate a "chilling effect".

Furthermore, a survey of hospital executives, relied upon by AHA, actually does not support the contention that collaborative activity is being deterred by antitrust policy. AHA cites a study that indicated that 44 percent of hospital CEO's who responded agreed that antitrust concerns have slowed down or inhibited collaborative efforts.[12] Yet, the same study showed a majority of respondents (54 percent) disagreed with that statement, while 72 percent of respondents were either engaged in or contemplating mergers or other collaborative activities.[13] This hardly suggests that the present level of antitrust enforcement imposes undue burdens on parties contemplating a merger. Indeed, regardless of whether there were a relaxation of standards for reviewing mergers, it would appear that the parties to a merger would develop the information presently sought by antitrust enforcement agencies in order to make sound business decisions.

AHA has failed to make its case that a fundamental conflict exists between the antitrust laws and hospital cost containment efforts. AHA contends that the antitrust laws unduly focus on market concentration and fail to give appropriate weight to potential efficiencies that may be created by collaborative activities. Certainly, the fact that a collaborative effort may create efficiencies is highly relevant to an antitrust analysis, if efficiencies will truly be created. However, as HHS points out, the fact that relatively few mergers are challenged suggests that concerns other than market concentration are factored into the analysis.[14] In at least some cases where hospital mergers were successfully challenged despite the purported creation of efficiencies, the result appears to have less to do with a failure to consider potential efficiencies than with a failure of the proponents of the merger to show that the benefits actually would occur.[15]

From the standpoint of the consumer the burden of proof must be on the provider to demonstrate: (1) that any proposed merger or joint activity will produce real world benefits (such as reducing costs) without compromising patient access to care or the quality of that care; and (2) that the contemplated activity will *not* afford the opportunity for providers to gain sufficient market share to anticompetitively raise prices.

In fact, it is not clear that hospital mergers will necessarily produce the efficiencies claimed. To quote HHS, "[c]onclusive statements about the effect of mergers

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[11] Department of Health and Human Services, Report of the Secretary's Task Force on Hospital Mergers, at 11, January 1993.

[12] American Hospital Association, Hospital Collaboration: The Need For An Appropriate Antitrust Policy (1992), at 21 (citing Julie Johnson, Collaboration Grows Despite Antitrust Rules, Hospitals, April 20, 1992, at 60).

[13] David Burda, Mergers Thrive Despite Wailing About Adversity, Modern Healthcare, October 13, 1992 at 27.

[14] *Id.*, at 27.

[15] *See, e.g., Federal Trade Commission* v. *University Health, Inc.*, 938 F.2d 1206, 1223 (11th Cir. 1991) (holding that "appellees here have not presented sufficient evidence to support their claim that the intended acquisition would generate efficiencies benefiting consumers.").

on cost and access to hospital care cannot be made".[16] Indeed, there are reports that at least some hospitals after mergers were able to increase net patient revenues and mark up rates "because they commanded greater market power and could control pricing more effectively".[17]

AARP agrees that enforcement agencies have an obligation to communicate their enforcement policies to those affected by them. However, based on the numerous presentations given by Federal Trade Commission and Department of Justice officials at trade and bar association meetings, it seems this obligation has been met. The message they are sending is that collaborative activities that produce genuine benefits can go forward. AARP sees no reason to change the message.

The Pharmaceutical Manufacturers Association (PMA) proposal

To avoid government controls on prescription drug prices, the Pharmaceutical Manufacturers Association (PMA) seeks to demonstrate that pharmaceutical companies can voluntarily adopt price restraints. PMA would like to have its member companies get together to discuss specific restraints and methods of enforcement without the threat of prosecution under the antitrust laws. Although the goal of restraining prices is laudable, the method proposed is dangerous. Anytime competitors get together to discuss and agree upon elements of price—whether minimum or maximum—the consumer is at risk. The maximum increase has the potential to become the minimum increase, and companies that begin with the praiseworthy objective of holding down prices can easily fall into the anticompetitive agreement to restrain prices *only* a certain amount.

In addition to the potential for consumer harm, an antitrust exemption is unnecessary to achieve pricing restraint. As an alternative to collaboration on price, PMA proposes that the Administration seek commitments from individual pharmaceutical companies to restrain price increases. Individual companies can unilaterally decide to restrain price increases or provide data to government agencies concerning their price structure without violating the antitrust laws. Indeed, PMA reports that ten pharmaceutical companies representing over 40 percent of the dollar sales of prescription drugs in the nation have already made public commitments to restrain their price increases. These companies did not need nor did they seek an antitrust exemption in any form before making these commitments.

AARP believes that the voluntary actions of these companies present the strongest evidence against the need for granting any antitrust exemption for the PMA and its member companies. The PMA can collectively propose to the government mechanisms for restraining price and encourage its members to voluntarily and independently restrain their price increases under the antitrust laws as they presently exist. AARP supports appropriate regulatory efforts by government, but views private regulation of price, particularly by interested parties, with deep skepticism.

For example, a recent report by the U.S. Senate Special Subcommittee on Aging revealed that of the eight major pharmaceutical companies that made voluntary pledges to restrain their price increases in 1992 to the change in the Consumer Price Index (CPI), none met their goal in the outpatient sector—primarily cash-paying consumers. Indeed, the increase in outpatient prices for some of these companies was three to four times greater than the change in the CPI.

Many of these companies, however, have argued that they met their pledge by using a "weighted average" price increase calculation, which includes the substantial discounts they give to the inpatient sector—hospitals, health maintenance organizations, and other large buyers. While this may be true, it is clear that voluntary price restraints may have little if any impact on outpatient prices. More importantly, it brings into question the seriousness which should be accorded the claims of a "new day" in pharmaceutical company attitudes about drug prices.

AARP is concerned about these findings since older Americans, more than any other age group, purchase their prescription drugs out-of-pocket in the outpatient market. A recent survey commissioned by AARP showed that compared to other age groups older Americans:

- Use significantly more prescription drugs to maintain their health;
- have significantly less health insurance coverage for prescription drugs; and
- incur significantly higher out-of-pocket costs for purchasing prescription drugs.

As a result, older Americans are having a much more difficult time in gaining access to needed drug therapies, especially as outpatient drug prices continue to esca-

[16] Report of the Secretary's Task Force at 12.
[17] Jay Greene, Do mergers work?, Modern Healthcare, March 19, 1990 at 24.

late. Clearly, voluntary price restraints by pharmaceutical companies that do not apply to the outpatient market will do little to improve access for cash-paying older Americans. What would improve access is the inclusion of prescription drugs in the standard benefit package for all under a reformed health care system, and AARP commends the PMA for its support of such a proposal. Inclusion in the benefit package would allow payers to use market power to encourage price competitive behavior on the part of manufacturers. That is beyond the power of an individual purchasing drugs out-of-pocket.

On the facts, AARP believes that Congress should not provide any antitrust exemption to the pharmaceutical industry. Such an exemption is not necessary and could be used to the detriment of consumers by allowing manufacturers to share information on how to "game" price restraints to their advantage or engage in other anti-competitive practices.

CONCLUSION

These hearings are taking place in the context of a wide ranging review of the entire health care system. AARP looks forward to active participation in this process. In light of the obvious need for innovative solutions, AARP finds it disheartening that so much of what has been proposed to this subcommittee reformulates previously discredited approaches to health care delivery.

The Federal Trade Commission and the Department of Justice have been active in challenging private restraints on the competitive, business, and financing aspects of delivering health services. These actions have helped contain health care costs. If the special interest exemptions that have been requested are enacted, this protection would come to an end, and costs to consumers and taxpayers would likely go even higher.

We welcome any questions the subcommittee might have.

Senator METZENBAUM. Thank you very much, Mr. Matthews. We will have 10-minute rounds, one round for each member.

Professor Havighurst, the FTC and the DOJ have been criticized for failing to provide clear guidance on how cost-cutting efficiencies will be considered. The head of FTC's health care section recently outlined how those efficiencies will be evaluated. Specifically, in a close case the parties will have to show that efficiencies are substantial, that they cannot be achieved without the merger, that they are not offset by reductions in quality, and that they are likely to flow to consumers.

As a practical matter, are cost-cutting efficiencies considered by the FTC and the Antitrust Division?

Mr. HAVIGHURST. I think I am aware of the statement that you refer to. I agree that one should be very skeptical about the efficiency defenses that are made for mergers. Every proponent of a merger claims that efficiencies will result, and very often in the past in other industries, certainly, those expectations were disappointed. On the other hand, in health care there is a lot of room for improved efficiency and I think these claims should be taken quite seriously.

It is also appropriate to consider whether the efficiencies can be obtained by some action stopping short of a merger, a joint venture, shared service arrangement, or otherwise. I do not agree, I think, that it ought to be shown that consumers will somehow derive the benefit of efficiencies if they are derived. If there are efficiencies, I think we should do all we can to capture them for the society as a whole. Whether it falls to the hospital or to the consumers is, I think, not a matter that ought to enter into the decision on the part of the agencies whether or not to recognize the defense.

Many of the hospitals, of course, are nonprofit so that any efficiency gains accrue to the community in the sense that the non-

profit serves the community. Even if it is a for-profit firm, I think that efficiencies are worth having and that mergers ought to be permitted if efficiencies are clear.

The real issue is always how do you balance real efficiencies against real competitive loss, and that is a hard call. Nobody knows how to make it well. I would decide for efficiency even if it resulted in a monopoly if I was truly persuaded that significant efficiencies were at stake.

Under managed competition, it seems to me we are going to have excellent opportunities to appraise these claims in the first place, and in the event we decide to allow a merger to monopoly, as in the Ukiah case, it seems to me the HIPC could then be authorized to act in a somewhat different role and, in fact, help to capture some of the benefits from the efficiencies.

Senator METZENBAUM. The AMA has proposed legislation that would provide an antitrust exemption for fee-setting agreements among small groups of physicians. The AMA has used a number of arguments to justify their proposal. For example, the AMA claims that an agreement by physicians on a fee proposal does not raise the same potential for harm to competition that ordinarily arises when competitors reach an agreement related to price.

Do you agree with the AMA's assertion that there is less possibility of competitive harm when doctors' groups agree on the fees that they will charge?

Mr. HAVIGHURST. No, I don't agree with that. I think the mechanics of this are difficult to capture. I am not sure I can convey this very well, but it seems to me what the profession really wants to do is to propose something on the name of the local providers and then have the payers declare themselves as either being friendly to that proposal or opposed to it.

In other words, the payer has to take a position as a friend or foe of the local doctors. To go against the local doctors is difficult. What is likely to happen in many cases is that all the payers will go along. In other words, what the profession is trying to do is to set a term on which all the payers can agree, and we will use your fee schedule. That is what happened in the *Maricopa* case. All the payers uniformly fell into line behind the fee schedule that the doctors proposed. That is illegal, and I don't think we need to have the doctors proposing terms on which all the payers can agree in the future.

I think it is high time that the profession gave up this campaign to try to tinker with fee-for-service insurance and went to the task of reorganizing medical care in America along the lines of managed competition and managed care.

Senator METZENBAUM. Doctors, hospitals, and drugmakers have claimed that the antitrust laws are chilling or preventing certain procompetitive deals. I am frankly skeptical of their claims. Last June, the Bush administration's antitrust chief testified before the Joint Economic Committee. He warned that "No amount of structural reform will succeed if health care providers are organized into tightly-knit cartels that reduce output, increase prices, stifle innovation, and restrict entry." Do you agree with that statement?

Mr. HAVIGHURST. I agree with it. I think we need to get doctors organized into competing health plans so that their main concern is to serve their patients better.

Senator METZENBAUM. Thank you very much. Mr. Devitt, I am must say that I really question whether the FTC should have brought a case against your hospital.

Mr. DEVITT. Thank you, Senator. I agree. [Laughter.]

Senator METZENBAUM. However, I want to say that I think maybe your lawyers bear some responsibility for running up the legal bills. It is my understanding that there was a refusal to comply with an FTC subpoena which led to the Commission's decision to sue you, and then you fought the Commission's administrative action on jurisdictional questions.

I think every litigant has the right to fight on every possible ground, but in addition to that, you filed two separate cases in Federal district court in San Francisco and Washington, DC, challenging the Commission's jurisdiction to sue a nonprofit hospital. Both of those cases were dismissed. Now, I could just see those fee bills running up in Washington and San Francisco.

I am not suggesting that your ordeal has been self-inflicted or that you didn't have a legal right to raise jurisdictional issues in fighting the suit. However, I do want to say I think you spent an enormous amount of money to litigate a question of jurisdiction, and I wonder whether your case couldn't have been resolved in a less costly manner if you had just defended on the merits from the beginning because I think there are considerable merits in your case.

Mr. DEVITT. Well, Senator, certainly, if the FTC had issued an injunction from the beginning, as they have in the Punta Gorda case in Florida and in some other cases, we could have gotten directly to the issues. As we got into this, the reason we went to court is that we thought the FTC had indeed given us the decision on the jurisdiction and when we tried to go to court to appeal that, they would then come back and say, no, we haven't given you a decision, your process isn't over yet. That is why we were taken out of court and back into the FTC, and this dragged on and on.

Had an injunction been given to bring this thing to a head, yes, it probably could have gone much quicker, but, you see, that didn't happen. We did provide them with lots of information. Whenever they asked for it, we provided it. I think we provided them with very adequate amounts of information regarding the efficiencies that we were experiencing and the conditions in our community that brought this situation about.

Senator METZENBAUM. I almost feel as I sit here that the conduct of the FTC was questionable, the procedures of your legal counsel were questionable, and the hospital got stuck in the middle, and I think you are paying the price. I understand it is close to a resolution and I hope it gets resolved and you continue doing that which appears to be a pretty good job in your area.

Mr. DEVITT. Thank you, Senator.

Senator METZENBAUM. Mr. Rothschild, normally companies in your business would compete aggressively on the basis of innovation and quality. In fact, I think one of the toughest problems in

your business is keeping the doctors and the patients informed about the new kinds of artificial limbs that are available.

You testified you have been shut out of the National Rehabilitation Hospital, which unquestionably has one of the largest prosthetic clinics in the Washington, DC, area, and that they refer all of their amputees to its joint venture partner to be fitted for artificial limbs. How can the amputees find out what different kinds of artificial limbs are available to them if they are steered to one specific prosthetic company by the hospital where they are being treated?

Mr. ROTHSCHILD. Well, Senator, actually it does become a relatively limited choice, particularly as you compare it to the way it once was prior to Medlantic's entry into the market. Prior to that, the competing companies would meet at a given hospital clinic where a patient was presented and a consensus of opinion of all the team members—the physician, the therapist, the competing companies—and this consensus of opinion would be based upon a given track record, a proven methodology that worked. So, consequently, the patient did receive the necessary information in order to have the physician prescribe a prosthesis.

Senator METZENBAUM. Why haven't you filed an antitrust suit?

Mr. ROTHSCHILD. Excuse me, Senator?

Senator METZENBAUM. Why haven't you filed an antitrust suit?

Mr. ROTHSCHILD. Well, it is like a catch–22, Senator. We were experiencing financial difficulties already. We are relatively small business. To bring such a suit is a very, very expensive proposition.

Senator METZENBAUM. You can't get it taken on a contingent fee basis?

Mr. ROTHSCHILD. Most attorneys that we talked to literally told us to forget it. It was an impossible endeavor. Even if you were to win—and the track record of winning these kinds of things against hospitals, evidently, is not very good, and they told us even if you did win, the recoverable damages would not in any way near approximate your costs. So, for us, it was just a given. It was only through a friend of my son's in college that we were able to get attorneys to help us out on this to get it this far.

Senator METZENBAUM. Thank you very much. Mr. Matthews, my failure to ask you any questions is not an indication that I am not greatly appreciative of your testimony. I think the testimony of the AARP on this subject is very significant and we look forward to working with you.

Let me turn you over to a person who is not eligible for membership in the AARP, Senator Thurmond. [Laughter.]

Senator THURMOND. Thank you very much, Mr. Chairman. Mr. Havighurst, do you think the enforcement agencies should attempt to reduce uncertainties about application of the antitrust laws in the health care field by issuing more detailed policy statements and guidelines?

Mr. HAVIGHURST. That is always helpful, Senator, though I do think the agencies have made a significant effort in this area. It is a terribly difficult analytical problem one confronts with hospital mergers and joint ventures. There is no way of making it easy and clear. I think that is the difficulty here.

Because concentration in some of these markets is so high, the basic antitrust presumption is that this is a very questionable undertaking. Then the question is, well, what efficiencies will be yielded. We don't always know that with enough precision to make an easy decision about the tradeoff. That is the difficulty, and a lot of general statements help some, but they don't resolve individual cases very well.

Senator THURMOND. Do you support the proposals in Senator Cohen's bills for hospitals to be permitted to enter into agreements to share medical technology and services?

Mr. HAVIGHURST. Well, no, Senator. I think these decisions ought to wait until we see what the President's health reform proposals look like. I think, in that context, it might well be decided that the State of Maine can go its own way on such matters. I think we could decide that in rural areas special rules ought to apply, or we might just decide to leave it to managed competition, to HIPC's, which have responsibility for care and competition in a given area. Where markets aren't competitive enough, the HIPC might be given extra powers to deal with that situation.

Senator THURMOND. Thank you. Mr. Devitt, if there were too many beds in the two hospitals that merged in Ukiah—do you pronounce that Ukiah?

Mr. DEVITT. Yes.

Senator THURMOND. Why has the number of beds not been reduced since the merger?

Mr. DEVITT. We have not reduced the number of beds, but we have reduced other expensive services. We are in the process of reducing beds when we get moved on to one campus. We are recognized by the State of California as one hospital, but we are still in two buildings. The number of beds, at 43 at the campus of our hospital that purchased Ukiah General, was not adequate under all circumstances to take care of the patients. We are in the process of rectifying that and moving along.

The process would have been speeded along considerably had it not been for the $1.7 million that we have spent defending ourselves against the FTC, and that has been a deterrent in this case.

Senator THURMOND. Would you favor allowing small rural hospitals to merge even if there are no other competing hospitals in the market?

Mr. DEVITT. Well, certainly from an efficiency standpoint, Senator, you know, as a hospital administrator I would say that that is a good idea because I know how inefficient small hospitals are and how expensive they are and how difficult it is to compete against your big neighbors. Even in our case now, as a 50- or 100-bed hospital, we are in a far better position to compete against the hospitals in Santa Rosa than we ever were as two 50-bed hospitals. We spent all of our time beating up on each other and not paying attention to the guys who were really eating our lunch, and that was Santa Rosa.

Senator THURMOND. Mr. Rothschild, do you have any evidence that costs for prostheses have increased in Medlantic or that selection and quality are inferior there?

Mr. ROTHSCHILD. Well, Senator, we have heard patients and physical therapists complain that, in fact, they did experience addi-

tional costs that we would consider above the norm. We have heard patients complain of being kept in that facility for an inordinate amount of time with questionable goals and results.

So we have seen that, and we have seen patients who have been through the facility and have not been satisfied with the prosthesis——

Senator THURMOND. Speak into your microphone. We can't hear you.

Mr. ROTHSCHILD [continuing]. Have not been satisfied with the prosthesis they received.

Senator THURMOND. If, as you testified, Medlantic offers inferior selection and quality of prostheses at increased cost, why do you think that the other hospitals in the area are sending their patients there?

Mr. ROTHSCHILD. Well, I think, Senator, that one of the best examples I can give about that is when we were at a clinic at the Washington Hospital Center just prior to Medlantic coming on the scene, there was a physician in the Washington Hospital Center who referred patients to us. Well, when the National Rehab facility opened, those referrals ceased until about a year ago when that physician got back in touch with us and asked us to continue to see his referred patients.

So it took some ingredients to be there for us to get back into it, and one was the fact that this physician had known there was a better way of doing things, had become dissatisfied with the NRH facility, a facility that he also works for, and we were still in the area so he still had a choice.

Senator THURMOND. Are you an orthopedist yourself?

Mr. ROTHSCHILD. I am a prosthetist and an orthopedist.

Senator THURMOND. I have no more questions. Thank you very much.

Senator METZENBAUM. Senator Hatch?

Senator THURMOND. Just a minute, Mr. Chairman. Mr. Matthews, I think your testimony is so clear, you don't deserve any questions. Thank you for being here.

Mr. MATTHEWS. Thank you very much, Senator.

Senator METZENBAUM. Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman. Professor Havighurst, I am glad to see in your testimony that you, as an eminent scholar, are concerned about drug price controls. As you probably know, I too have been very concerned about that, about the prospect of drug price controls. I not only don't think they will work, I think they will work in retrogression rather than progression.

Now, in your testimony you elaborated your opinion that the Justice Department can exercise prosecutorial discretion not to prosecute the drug industry in response to the PMA request for a business review letter. If it is your position that DOJ should not prosecute under antitrust laws, wouldn't some more definite relief by DOJ be preferred to avoid the threat of a possible enforcement chilling effect?

Mr. HAVIGHURST. Well, I am not sure what else the Department could do. It would require congressional action to give any affirma-

tive exemption to the PMA, which certainly could be considered. I would like to see this come from the President. I would think——

Senator HATCH. Well, I would like to see you maybe help us here in the committee by giving us some ways more definite relief might be accomplished, maybe a waiver process or something like that. Could you give us the benefit of your advice, if not today, in the future?

Mr. HAVIGHURST. There is nothing in place today for the Department to grant an exemption. All they can do is say we won't prosecute. That leaves it open to private suits. I am not sure who would bring a private suit for this particular kind of conduct because holding prices down doesn't seem to injure anybody very obviously.

The FTC could bring an action, but presumably they would follow whatever lead Justice gives, so perhaps the chilling effect is not too serious. I would think that that is a plausible strategy for the administration to follow in trying to smooth over this period from now until managed competition gets some price restraint without embarking on a long-term, heavy-handed regulatory program at the Federal level.

Senator HATCH. You indicated that if we get managed competition that that in and of itself will create a price restraint condition through bulk sales, et cetera, et cetera, and I tend to agree with that.

Mr. HAVIGHURST. Indeed, I think that managed competition solves many of the problems we have been hearing about. It certainly would help the problem of Mr. Rothschild. If we had more active purchasers in that market selecting on the basis of cost and quality, he would be chosen ahead of his competitor in many instances. I think we have in managed competition a really attractive solution to this problem without using antitrust as the vehicle for trying to solve this problem.

Senator HATCH. Of course, I notice that, you know, under current conditions the AARP, for instance, has its own mail order drug division, and I presume that they make profits off of that. You know, it is an interesting thing to me. But if you could give some thought as to whether or not there should be some definitive relief or some better way for companies to gauge just what are the potentials here and give us some advice on that maybe in a letter later or whenever, I would surely like to have the benefit of your good thinking.

Mr. HAVIGHURST. I would be glad to try.

Senator HATCH. I was eager to see in your testimony that you, as well as I, recognize the urgent need for us to think about how antitrust laws affect our activities in health care reform. Can you give us any guidance to predict the behavior in rural areas, for instance, with a HIPC acting as a monopsony purchaser and the AHP acting as a monopoly seller?

Mr. HAVIGHURST. The model I have in mind, Senator, is just a model that I kind of cooked up. I did share it with the task force and at least some people there were interested. In fact, I am submitting with my testimony a copy of a memo I provided to the White House Task Force on Health Reform just for the record. It covers some of the ground in the testimony, but says a little more about how I think HIPC's would function.

I visualize them as being true cooperatives representing purchaser interests, and I see their main function as being to just sort of set the menu of health plan options that are available to all the consumers in the area. Now, in an area where there aren't many health plan options, or really more than one, and there are only one or two hospitals and very limited supply of physicians, we have a problem of whether we are going to ever get any competition going.

In that context, I can imagine the HIPC being authorized under a procedure to step out of the role of simply managing competition procompetitively into a more regulatory role where it would, in fact, be able to, if not dictate prices, at least engage in a one-on-one bargaining with a monopoly plan or provider. I would think we could get satisfactory results by that process, but it is certainly a matter that needs careful thought.

I think, in fact, in any market you are going to find some services that are going to be not provided as competitively as others, and that the HIPC ought to have some ability to deal with those situations where competition isn't all that it might be. There are a range of tools that could be made available, including antitrust enforcement if there is a provider cartel, or including moving to a more regulatory mode if that is the only alternative.

Senator HATCH. Well, thank you. I appreciate those responses.

Mr. Devitt, is that how you pronounce your name, Devitt?

Mr. DEVITT. Yes, Senator.

Senator HATCH. The FTC prosecution in your instance has been going on since November 1989.

Mr. DEVITT. Yes, sir.

Senator HATCH. Irrespective of the merits of the case, how has the pendency of this prosecution affected your hospital's ability to deliver health care within your community?

Mr. DEVITT. Well, Senator, earlier I was asked about the consolidation of the hospital into one campus and the reduction of beds, and so on. Certainly, the expenditure of the $1.7 million has had an effect on our ability to do that.

Senator HATCH. You only have 14,000 people there?

Mr. DEVITT. We only have 14,000 people in town.

Senator HATCH. Where does that $1.7 million come from?

Mr. DEVITT. Part of it comes from—well, a good share of it comes from the moneys that we are paid for Medicare and MediCal patients. It doesn't affect the payment any. We don't get more because we are involved with the FTC.

Senator HATCH. So you are looking for every efficiency you can get and saving every nickel you can so you can pay for these what you consider to be unnecessary costs?

Mr. DEVITT. Yes, Senator, and at the same time during all of this adversity we have still been able to hold our price increases to about half of what the rest of the State of California has averaged during the same time period.

Senator HATCH. Well, maybe we had better move, instead of managed competition, to rural competition and impose that on the cities.

Mr. DEVITT. We have a model we would like to show you. [Laughter.]

Senator HATCH. I would like to see it. I am very, very interested in it. You have made some references to the improvement of the quality of medical care and how combining the two small hospitals actually leads to efficiencies and improvement in the ability to give even better medical care, and I appreciate having that.

Just one last question. What effect has the merger had on your hospital price growth rate, both on growth previous to the merger and projected growth as well?

Mr. DEVITT. Prior to 1988, both Ukiah General Hospital and Ukiah Adventist Hospital, as it was known at that time, were pretty much in the ballpark with the rest of the State of California, with price increases running—it varied from year to year, but from 10 to 12 percent a year. There was one year in about 1985 when I think the price increases were almost 18 percent. Since that time, the highest increase we have had since 1988 was 7.5 percent, and most of the increases have been 5 and 5.5 percent.

Senator HATCH. Well, I commiserate with you because I think that sometimes instead of debilitating litigation that really eats up very, very scarce funds, especially in your case, but in almost every case, we ought to be looking for reasonable ways to resolve some of these problems that save money for everybody and get better health care for people.

Mr. DEVITT. Thank you, Senator.

Senator HATCH. That is easier said than done, so I have a lot of empathy with what you are saying here today and I hope that this gets resolved because it seems to me to be ridiculous.

Mr. DEVITT. Thank you.

Senator HATCH. Mr. Rothschild, aren't all doctors in the Washington area free to contract with you, just like the one from Washington Hospital Center apparently did before?

Mr. ROTHSCHILD. They are free, Senator, but they don't.

Senator HATCH. They don't?

Mr. ROTHSCHILD. The majority of them send their patients to the NRH facility.

Senator HATCH. OK. Well, Mr. Matthews, I agree with Senator Thurmond. There is no question that senior citizens, like most Americans, are very concerned about high health care costs and we are going to try and do something to get those costs contained. In that regard, I want to compliment the AHA and the PMA for coming here today and being willing to participate in these hearings because I think it is a good-faith effort to try and discuss the problems and see what we can do to resolve them.

I have to say that around here sometimes there is an ability to play populist politics at the expense of good research and future development of life-saving drugs, and we have got to hit a happy medium and a happy balance here somehow or other, and price controls ain't the way to get there. But, unfortunately, there are those who think that that is the answer, or at least feel that it is a good populist issue that they can get people worked up on because drug prices are expensive.

But we also have the potential of resolving some very serious problems that are right on the cutting edge right now that could save us trillions of dollars over the next number of decades. So we

have to hit that happy medium and I intend to make sure that the free market system is not upset in the process.

Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much, Senator Hatch, and I want to thank each of the members of this panel. Your cooperation is very much appreciated. Your entire statements will be included in the record. Thank you.

Our next and last panel is Fredric Entin, senior vice president and general counsel of the American Hospital Association; Richard F. Corlin, M.D., vice speaker of the AMA House of Delegates and president of the California Medical Association, speaking on behalf of the AMA; and Bruce Brennan, senior vice president of the Pharmaceutical Manufacturers Association. We are happy to have each of you gentlemen with us.

Mr. Entin, would you care to proceed first?

PANEL CONSISTING OF FREDRIC J. ENTIN, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC; DR. RICHARD F. CORLIN, VICE SPEAKER, HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL, ACCOMPANIED BY KIRK B. JOHNSON, GENERAL COUNSEL, AMERICAN MEDICAL ASSOCIATION; AND BRUCE J. BRENNAN, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, PHARMACEUTICAL MANUFACTURERS ASSOCIATION, WASHINGTON, DC, ACCOMPANIED BY THOMAS DOWNS, COUNSEL, PHARMACEUTICAL MANUFACTURERS ASSOCIATION

STATEMENT OF FREDRIC J. ENTIN

Mr. ENTIN. Thank you very much, Senator. I am Fred Entin, senior vice president and general counsel of the American Hospital Association. I will try to go briefly through my remarks because many of the points I wished to make have been made already at this hearing. I am pleased to be here to share with the committee the views of the 5,300 institutions that are members of the AHA.

Let me repeat what has been said here already, and that is the United States is on the verge of health care reform, and I would appreciate that you understand that our comments are being made in the context of health care reform when we discuss antitrust.

It has also been remarked that the current system that we have is fragmented, uncoordinated, costly and inefficient, and therefore the need for reform is here. Like many others, the AHA at this time envisions a future health care system founded on community-based provider networks. These are very much like the accountable health partnerships that Mr. Havighurst was referring to and that have been discussed in the context of managed competition. We believe that cooperation and coordination among providers within a network offers the best approach to health care reform and a rational delivery of services in an efficient way.

In the 1980's, it was thought that competition between these individual providers would yield a more efficient health care system. We believe that experience tells us that competition exacerbated rather than alleviated the health care crisis.

Antitrust laws which encourage competition assume that market forces will eliminate excess capacity, but market solutions will take longer to achieve needed reductions than will collaborative strategies. Given the relationship of health care spending to the economy, the faster costs associated with health care can be reduced, the better.

We also believe that competitive solutions may produce some socially undesirable results. We may find market forces dictating the closure of facilities in communities least able to afford it. Finally, other noneconomic priorities of health care—specifically, quality—may be impaired in those institutions that struggle to remain in business long after they should close. I would refer the committee to the appendix in our white paper which discusses studies that examine the relationship between concentration and prices in health care.

As I said, the American Hospital Association's reform plan calls for and is founded on the principle of community care networks, much like the accountable health partnerships that are being discussed widely right now. These are consortia of hospitals and other institutional providers, physicians, health insurers, employers, community health organizations and others working together to furnish all necessary health services to patients with integrated care organized at the community level. We see payment to the network on a prepayment or capitated basis to align incentives within that network to achieve needed efficiencies and cost reductions.

Our plan has much in common with other proposals, almost all of which right now favor some form of provider networks. You have asked, Senator Hatch and Senator Metzenbaum, whether antitrust is a problem when it comes to health care policy. Is it an obstacle to health care reform?

Well, if the goals of health care reform are to achieve greater access, maintain and improve quality, and control costs through reduction and conservation of resources, and if the mechanism by which those goals are to be obtained is through collaboration of providers in organized, comprehensive, integrated networks of care, then I would have to say that the answer is yes.

We see three dimensions to the problem. The first is a misunderstanding, and the American Hospital Association has understood that and accepted the responsibility to work with our members and educate them about the reach of the law and to encourage them to explore a variety of cooperative arrangements which have little or not antitrust risk.

The next aspect of the problem concerns a variety of activities which further network development about which there is inadequate guidance, where many are unwilling to act due to uncertainties over whether they will be drawn into an expensive, time-consuming challenge by competitors or the enforcement agencies, such as Mr. Devitt experienced.

Forty-four percent of hospital CEO's polled by Hospitals Magazine recently said that antitrust concerns slowed or inhibited collaborative activities. Five States, including Senator Cohen's State of Maine, have already addressed this part of the problem as a matter of public policy. In those States, legislation has been passed protecting hospitals pursuing health reform arrangements. Similar

legislation is pending or being considered in at least 17 other States.

The FTC and the Department of Justice have said that there is adequate guidance to be found in their joint merger guidelines and other public statements. From the testimony given by Chairman Steiger, however, it is not clear how those guidelines and how those policies are applied. As we have heard, there is a presumption of illegality in perhaps 80 percent of all U.S. communities pursuant to the concentration guidelines.

What the real problem is is that neither the guidelines nor any other policy pronouncements enable hospitals to clearly distinguish circumstances in which specific collaborative arrangements will, in fact, be challenged and those in which they will not. We look forward to Chairman Steiger's offer to provide information regarding the efficiencies that are considered in approving those arrangements in the future because the absence of challenges, rather than ease the situation, serves to exacerbate the confusion that exists over how the law will be applied.

Finally, the third dimension——

Senator METZENBAUM. Take another minute or two.

Mr. ENTIN. All right. Thank you, Senator.

Finally, the third dimension of the problem would relate to the evolution of networks. As they continue to evolve and as they reach a point in their development where further efficiencies may require decisions regarding allocation of resources, the network may have to make decisions about the disarming of the medical arms race and eliminating redundant and duplicative technology, as well as excessive capacities, within a network.

For example, if the enrolled population only needs one MRI and one lithotritor, under current law it would be illegal for one hospital in that network to decide to purchase the MRI and the other hospital in that network to agree to purchase the lithotritor, even though there may be broad community support for that kind of rational decisionmaking to service that community and that population.

As the future of health care policy is set, antitrust laws need to accommodate the direction in which that policy is headed—networks of care. The AHA is not alone in calling for such an accommodation.

In conclusion, we would ask for a thoughtful examination of the antitrust policy in the context of health reform. We believe collaborative strategies will work, and thus unnecessary barriers in the law, antitrust and otherwise, need to be eliminated. If networks are an integral part of health care reform in this country, the appropriate goal would be to encourage competition between networks. Policies, however, that inhibit the formation of networks or collaboration within those networks may be inconsistent with the goals of health care reform. Protecting the interests of patients is the underlying objective of both the antitrust laws and health care reform. Therefore, those policies should be reconcilable.

Senator, if I might, I would like to just respond to a comment you made at the outset of the hearing regarding a proposal, or a belief that we have a proposal seeking an exemption. We put together as an option for consideration the possibility that a vol-

untary waiver program might be a way to accommodate network formation.

Those ideas were put forth at a time prior to this momentum had gathered with regard to health care reform and with the impending May 3 announcement by the Clinton administration of their plan. It is an option, it is a way of considering how one might get from here to there in terms of network formation. It is modeled, quite frankly, after what has been occurring in many of the States with regard to encouraging collaboration among health care providers. We have not put it forward as a legislative proposal. It is a way of looking at the problem, but, quite frankly, given the fact that we are on the eve of health care reform it may not be necessary once we hear from the administration.

With that, I will conclude my remarks.

Senator METZENBAUM. Well, we are pleased to hear that the AHA is sufficiently concerned about the problem that you have developed a concept of your own, and also pleased that you are now working with the administration to bring about a program that can serve all Americans. We look forward to working with you and appreciate your testimony.

Mr. ENTIN. Thank you, Senator.

[The prepared statement of Mr. Entin follows:]

PREPARED STATEMENT OF FREDRIC J. ENTIN ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

SUMMARY

The United States is on the verge of comprehensive health care reform. We are faced with the dual challenge of expanding access to care while conserving resources to contain the growing costs of providing health services. To meet this challenge, we will need to restructure the delivery system in a manner which encourages collaboration between health care providers. The country's antitrust policy must accommodate its health care policy.

AHA envisions a future health care system founded upon community-based provider networks. Many others in the policy-making arena contemplate similar approaches to providing coordinated care in a seamless system, rather than the fragmented system that exists today. Antitrust laws must be flexible enough, and provide sufficient guidance, to encourage the formation and operation of networks.

The benefits of collaboration are significant. From a cost containment perspective, providers can eliminate excess capacity, as well as wasteful and costly duplication of equipment and services, through joint activity. Collaboration also leads to improved access to and enhanced quality of care. Yet, current antitrust policy inhibits cooperative actions in various respects.

The continuum of antitrust issues with respect to provider collaboration includes certain cooperative activities that are specifically prohibited, other types of activity that are not prohibited but are perceived by providers as risky under the antitrust laws, and many collaborative arrangements for which have inadequate guidance exists. Where activity is not clearly prohibited, providers are dissuaded from moving forward because it is difficult and costly to determine whether a particular arrangement would be viewed as illegal.

Particularly given the imminence of health care reform, one of AHA's goals is to ensure that federal antitrust policy and national health care policy are truly compatible. AHA believes that certain principles undoubtedly must be acknowledged. Consumer interests are at the heart of both antitrust policy and health care reform. Provider collaboration can result in real cost containment, improved access, and enhanced quality of care. Health care is, at its core, a community-based service and collaborative efforts to meet community health needs should be encouraged.

ANTITRUST IN THE HEALTHCARE INDUSTRY

Mr. Chairman, I am Fredric J. Entin, General Counsel and Senior Vice President of the American Hospital Association (AHA). On behalf of the AHA's approximately

5,300 institutional members, I am pleased to testify on our view of antitrust in the health care industry.

This country is on the verge of comprehensive health reform. As we move toward reform, we are faced with the challenge of finding an acceptable balance between providing greater access to health care services and conserving health care resources. To meet this challenge, we will need to restructure the way health care is delivered in the United States. A necessary part of restructuring the delivery system will be the development of new and innovative relationships between and among providers. The AHA, along with many others, envisions a future health care system founded on community-based provider networks. It is crucial that the antitrust laws accommodate the creation of these networks.

THE NEED FOR CHANGE

The U.S. health care system is unique, both in its strengths and weaknesses. We have a wealth of health care facilities and highly trained personnel, and have long been recognized as a leader in the high quality of health care provided. Our health system encourages clinical innovation and is known for state-of-the-art treatments and technologies.

Despite these strengths, the United States health care system is seriously flawed. Foremost among its problems is inadequate access to health care coverage. There are currently 36 million uninsured individuals in the U.S., 10 million of whom are children. Half of the uninsured live in families with incomes below the poverty threshold. Medicaid, a program originally designed to provide health insurance to the poor, now provides care to only about 40 percent of people living in poverty. As a result of strained federal and state finances, those who do qualify for Medicaid face limitations on the services they receive. Many state Medicaid programs, for example, do not pay for screening and preventive services. Coverage limitations are becoming more common even for the privately insured, as many insurers eliminate benefits in an attempt to control their rising costs.

Another major problem with the current system is the continued rapid growth in health care spending. National health expenditures are rising at an annual rate of over 10 percent and the U.S. currently devotes more than 13 percent of its Gross Domestic Product to health care spending, more than any other nation in the world. However, we still suffer significant deficits in health status. Among the western industrialized democratic nations, the U.S. ranks first in health care spending per capita, but 20th in infant mortality.

Under our current system, the delivery of care remains fragmented. Individuals generally receive care from a changing array of providers and only after they have become ill. Patients are often left to patch together services in a variety of settings from unconnected providers. Our capacity for providing care is excessive in some areas and inadequate in others. For example, some hospitals possess a costly overabundance of high technology equipment, while others have trouble adequately filling their staffing needs.

The highly competitive hospital market of the 1980's exacerbated, rather than alleviated, this country's health care crisis. Market forces have failed to rationally allocate resources in a socially optimal manner and have led to wasteful and costly duplication. Because competitive solutions have failed, hospitals are seeking alternatives that better enable them to meet the needs of their communities.

AHA'S REFORM PLAN

Insufficient access, rising costs, and fragmentation of care have led to patient dissatisfaction with the current health care system. Americans question the value they are receiving for their health care dollars. The United States has the greatest health care available in the world, but our delivery system is in desperate need of repair.

The AHA's vision for health reform calls for universal access to a basic health care benefits package. The set of basic benefits would cover the full range of services from preventive care through long term care. Universal access would be provided by means of a pluralistic system of financing—a combination of private workplace coverage and a new public program consolidating and expanding Medicare and Medicaid. Employers would be first encouraged and ultimately required to provide coverage for their workers and dependents.

AHA's reform plan is founded on the concept of Community Care Networks℠, providers working together to furnish patients with integrated care organized at the community level. These networks would be consortia of hospitals and other institutional providers, physicians and other health care professionals, insurers, employers, unions and other groups. Networks would be responsible for providing all the covered health care services for their enrolled population and would coordinate patient

care over time and across various provider settings. Patients could turn to their network for everything from preventive care to acute care to long-term care services.

Community care networks would improve the quality of care because they hold the promise for true management of patient care. True managed care requires assessing patient health risks and needs, and planning, organizing, and delivering care so that problems are averted or treated early and all needed services are efficiently provided.

Community care networks, which would receive risk-adjusted capitated payments from purchasers of health care, would encourage providers to conserve health care resources by providing only appropriate and necessary care. Networks would also encourage providers to collaborate with one another to avoid duplication of services.

COLLABORATION CAN BE BENEFICIAL

The AHA is urging the formation of networks because we believe they are the best way for hospitals, other health care providers, businesses, schools, and community organizations to improve the health status of their communities. Greater provider cooperation will lead to controlled costs, improved quality, and expanded access.

Cost containment

Provider joint efforts can contain high costs by reducing excess capacity and duplicative services. A number of studies [1] completed since 1987 address the relationship between market concentration, which is a function of the number of competitors in a market and their respective market shares, and increased costs and/or prices. Market concentration typically increases when competitors merge or engage in other cooperative activities.

The government's antitrust policy assumes that greater market concentration is likely to lead to higher prices. Many of the studies referenced above fail to support this assumption. Instead, the studies provide direct or indirect support for the proposition that collaborative efforts can lead to greater efficiency. Some of these studies demonstrate a statistically significant correlation between higher market concentration and lower prices and/or costs. Other studies merely suggest that there is no positive correlation between higher market concentration and higher costs and/or prices. Overall, the studies cast doubt on the presumption that in concentrated hospital markets, increased market concentration, by itself, will lead to higher prices and/or costs to purchasers of health care services.

For example, a study published in June 1992 by the Inspector General of the Department of Health and Human Services (HHS) suggests that both operating and capital costs are lower in markets in which a merger occurred. The study also concluded that for merged hospitals, medical and other service costs were reduced 10.4 percent, while the same costs in the non-merged control group increased 29.7 percent.

In *In re: Adventist Health Systems/West,* a recent case in which the Federal Trade Commission (FTC) challenged a hospital merger in Ukiah, California, the Administrative Law Judge (ALJ) affirmed the notion that cooperative efforts can lead to greater efficiency. As the ALJ noted "[t]he facts belie" the claim that "competition among health care providers will give consumers the same benefits as competition in other industries. * * *" [2] The ALJ concluded that "[c]ompetition did exist between [the] hospitals * * * but it appears to have *increased* the costs of hospital care in the Ukiah area through duplication of services * * *" [3]

Quality

Provider collaboration can also improve the quality of health care. Provider cooperation, by consolidating the market, tends to increase the volume of procedures performed by any given provider. Studies have concluded that, at least for certain services, increased volume leads to reduced risks, greater proficiency, and higher levels of quality. The ALJ in *In re: Adventist Health Systems/West* implicitly supported this assertion when he noted that, "the creation of a hospital which is larger and more efficient * * * will provide better medical care * * *." [4]

Access

Provider cooperation can also increase access to health care services. A recent *Hospitals* magazine survey indicated that the two areas in which hospitals most fre-

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[1] These studies are specifically identified and discussed in Appendix D of the AHA's report, *Hospital Collaboration: The Need for an Appropriate Antitrust Policy.*

[2] *In re: Adventist Health Systems/West,* Docket No. 9234 at 44 (Dec. 9, 1992).

[3] *Id.* (emphasis added).

[4] *Id.*

quently collaborate are community outreach and the development of a continuum of care in the community.[5] Indeed, many cooperative activities have been motivated, at least in part, by a desire to maintain important but unprofitable services, including programs addressed to underserved population groups, and to spread the burden of those programs. Strict reliance on traditional price competition mechanisms, however, does not reward efforts to be sensitive to these social priorities. Federal enforcement standards do not recognize this dimension of the problem and, in at least one hospital merger case, the government expressly contested the hospitals' assertion that an enhanced ability to subsidize indigent care was a legitimate benefit of the merger.[6]

* * *

Whether AHA's concept of community care networks will be incorporated into this country's health reform plan is unclear. It is clear, however, that reform will take place and that it will entail new and novel provider relationships. Because current antitrust laws and enforcement pose an obstacle to the formation of certain provider relationships, a more flexible national antitrust policy will be needed.

ANTITRUST IS AN OBSTACLE TO COLLABORATION

The antitrust laws and their enforcement pose a range of problems for hospitals and other providers, particularly those seeking to form and participate in networks. Some collaborative activities that would be beneficial to patients and purchasers of health care are clearly prohibited under current law. Many other arrangements fall into a gray area, and it is unclear whether the antitrust laws would prevent their implementation. Finally, misunderstanding or misperception of the antitrust laws may deter some providers from engaging in joint activity that is in fact permissible.

Under current law, hospitals cannot agree to allocate services among themselves based on location or the type of services provided, even if the allocation is recognized as beneficial by consumers—including the business community, one of the largest purchasers of health care. For example, two hospitals cannot agree that one will purchase an MRI and the other will purchase a lithotripter, instead of each purchasing both pieces of equipment, despite the fact that the agreement could avoid unnecessary duplication of equipment and services. Such an agreement would be considered "market division," a *per se* violation of the antitrust laws.

This dilemma is illustrated by a recent inquiry from the president of the Wichita, Kansas Chamber of Commerce to the FTC. The Chamber of Commerce, expressing concern about the costs of unnecessary duplication of health care services in the Wichita area, asked whether the antitrust laws would prohibit the Wichita hospitals from meeting to collectively allocate services, equipment, or facilities among themselves. The Chamber of Commerce also inquired as to whether the involvement of organizations with wide community support in such allocation decisions could reduce antitrust risk.

The FTC responded negatively to the Chamber's inquiry, emphasizing that:

> An agreement among competitors to divide or allocate markets—whether on a geographic, customer, or product line basis—is per se illegal under the Sherman Act. Such agreements have been held to be so inherently anticompetitive they have been condemned without inquiry into whether or to what extent competition is actually affected by them. *Addyston Pipe & Steel Co.* v. *United States,* 175 U.S. 211 (1899). This rule of per se illegality governs private agreements among hospitals or other health care providers to divide markets.[7]

The FTC then went on to state that the involvement of community leaders could not alleviate the agency's concerns:

> You should however be aware that the mere fact that the community business leaders support or participate in an agreement among health care providers to allocate resources or services will not immunize or protect the

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[5] *Hospitals,* Feb. 20, 1993 at 56 (survey conducted by Hamilton/KSA).

[6] Deposition of Robin Allen, at 466–73 (Nov. 23, 1988), *United States* v. *Carilion Health Sys.,* 707 F. Supp. 840 (W.D. Va.) (No. Civ. A. 88–0249–R), *aff'd,* 892 F.2d 1042 (4th Cir. 1989).

[7] Letter from Mark J. Horoschak, Assistant Director, Federal Trade Commission, to F. Tim Witsman, President, Wichita Area Chamber of Commerce (May 22, 1991) (on file with the Federal Trade Commission) (hereinafter "Horoschak Letter").

providers or other participants from liability for an otherwise illegal agreement in restraint of competition under the antitrust laws.[8]

Most joint arrangements, including mergers, acquisitions, and joint ventures, are evaluated under the "rule of reason" standard, rather than the per se standard applicable to allocation agreements. The threshold question under the rule of reason is whether the arrangement creates or enhances "market power." Market power, which is generally measured by the rough proxies of market share and market concentration, exists when a party can profitably increase price above, or decrease output below, competitive levels.

Under the 1992 Merger Guidelines issued jointly by the FTC and Department of Justice (DOJ), virtually all communities with six or fewer hospitals are "highly concentrated" markets. Accordingly, in more than 80 percent of the United States communities that have more than one hospital, any reduction in the number of hospitals, through merger or acquisition, is presumptively illegal. Sound antitrust policy regarding hospital markets should highlight the potential for collaborative efficiencies and move away from a rigid focus on increases in market concentration.

Enforcement agency analysis of joint ventures also focuses on market concentration. Antitrust risks may be substantial, at least in communities with few hospitals, if two or more hospitals reduce existing duplication of services or equipment by joint venturing services in an area in which they currently compete.[9] Regarding joint ventures, the DOJ has stated:

> Notwithstanding the efficiency-enhancing potential of joint ventures generally, it is possible that a particular health-care joint venture could significantly increase health-care costs by significantly lessening competitive forces that are increasingly being relied upon to keep those costs down.[10]

In addition, the FTC has stated that the parties to joint ventures risk antitrust scrutiny by agreeing to a common price to be charged for the joint venture product:

> [A]n agreement among the venturers to impose the same charges for use of the equipment would not appear to be reasonably necessary to accomplish the purpose of the venture. Such an agreement, standing alone, would be unlawful, and depending on the circumstances could invalidate the joint venture under the rule of reason.[11]

Given the lack of precision in this advice, it is understandable that hospitals are often unsure of their joint venture alternatives. In fact, the DOJ recently acknowledged that adding certainty to antitrust enforcement is important, at least with respect to joint ventures involving high technology equipment:

> * * * pending legislation to reduce antitrust uncertainty and risk in the joint venture area generally may be of benefit to hospitals that wish jointly to purchase high technology equipment or services.[12]

Although this limited recognition of the problem is somewhat encouraging, the need to reduce uncertainty is no less important for other forms of beneficial hospital collaboration than it is with respect to joint acquisitions of high technology equipment.

Even where the antitrust laws may not pose a clear threat, other factors create a "chilling effect" on hospitals' efforts to work together. Inadequate guidance from the federal government (particularly given the current health care environment), the threat of lawsuits by competitors, the potential for treble damages and/or criminal prosecution, and the time and expense associated with challenges by enforcement agencies and/or private parties combine to inhibit hospital initiatives. In spite of the collaboration currently occurring within the hospital field, a *Hospitals* magazine poll indicated that more than 44 percent of surveyed hospital CEO's agreed that antitrust concerns have slowed down or inhibited further collaborative efforts.[13]

The federal enforcement agencies have stated publicly that hospitals should not be overly concerned about the lack of specific guidance relating to hospital markets because the government has challenged very few hospital transactions. The problem

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[8] *Id.*

[9] Where a joint venture is necessary to introduce new or enhanced products to a community, antitrust risks may be reduced.

[10] Letter from W. Lee Rawls, Assistant Attorney General, U.S. Department of Justice, to Senator Nancy Kassebaum, United States Senate (March 10, 1992) (on file with the United States Department of Justice Antitrust Division) (hereinafter "Rawls Letter").

[11] Horoschak Letter, *supra* note 7.

[12] Rawls Letter, *supra* note 10.

[13] *Hospitals*, April 20, 1992 at 60.

with this assertion is that neither the 1992 Guidelines nor any other policy pronouncement by the enforcement agencies enables hospitals to clearly distinguish the circumstances in which their specific collaborative arrangement would, in fact, be challenged from those in which it would not. Given that a large percentage of collaborative arrangements are presumptively illegal under the government's existing market concentration standard, the absence of challenges serves to create, rather than diminish, uncertainty. The uncertainty makes it difficult for hospitals to readily obtain clear legal advice on the validity of proposed transactions.

Nor is this uncertainty diminished by either of the two principal avenues for obtaining prior government review of joint arrangements. The Hart-Scott-Rodino Antitrust Improvements Act (HRSA), 15 U.S.C. para. 18a, establishes mandatory notification and review requirements for certain specified transactions, but does not preclude the agencies or private parties from later challenging the transaction. In addition, the time and expense of HRSA review is often substantial, particularly if the enforcement agencies request a large volume of documents and information, as they are authorized to do.

Parties to proposed joint arrangements not subject to mandatory HRSA review may seek advisory opinions from the federal enforcement agencies. For a number of reasons, however, the utility of these voluntary review processes is extremely limited. Perhaps most important, the process is simply too slow to be useful in many situations and provides little real help for hospitals seeking prompt and efficacious guidance regarding the likelihood of challenge to a proposed merger or joint venture.[14]

Where the problem is one of misperception alone, the AHA is attempting to address hospitals' antitrust concerns by educating its members. For example, the AHA has published a *Q & A Report* addressing the antitrust implications of collaborative activities. The AHA's educational efforts, however, cannot resolve the uncertainty inherent in the antitrust laws or change the laws' preference for competition, even where competition results in unnecessary duplication of services and equipment.

ANTITRUST POSES A SPECIAL PROBLEM FOR HEALTH CARE PROVIDERS

The antitrust statutes reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. * * * The assumption that competition is the best method for allocating resources in a free market recognizes that all elements of a bargain—quality, service, safety and durability—and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers."[15] For hospitals, however, competitively-structured markets may not produce an optimal allocation of resources.

In hospital markets, most individual consumers (including those who are beneficiaries of public programs) are insulated from market prices by third-party insurance. Moreover, individual consumers frequently lack the ability to choose particular hospital services, a task that is performed by, or at least shared with, physicians. Consequently, the person who pays for a hospital service (the insurer) neither demands it nor uses it.[16] The patient and the physician (who together create the demand) pay little or nothing for the service; therefore, the demand for hospital services is generally higher than it would be if patients paid the full cost for services.

Because insurance covers most of the cost of hospital care, patients (and their physicians) traditionally have had little incentive to select hospital services on the basis of price. If all hospitals effectively cost the same to individual patients (or the differences in coinsurance costs are relatively small), the patient and/or physician will select the one that offers the greatest combination of services, amenities, con-

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[14] In at least one case, the government response time exceeded three and one-half years. In any event, the response ultimately obtained may not be definitive. The DOJ recently began a pilot program intended to expedite the business review process. While we appreciate this acknowledgement of the problem, it is too soon to tell whether the pilot program will be successful.

[15] *National Soc'y of Professional Eng'rs* v. *United States,* 435 U.S. 679, 695 (1978).

[16] The FTC has acknowledged this fact, at least in theory:

> [H]ealth care markets differ in many respects from the textbook model of the competitive market. In particular, the relative lack of information available to patients, and the presence of health care insurance which blunts the impact of price on patients' purchasing decisions, have been cited as factors that may impede normal competitive processes in health care markets.

James C. Egan, Jr., Acting Director for Litigation, Federal Trade Commission Bureau of Competition, testimony at hearings on "The Structure of the Hospital Industry in the 21st Century" before the Subcommittee on Investment, Jobs and Prices of the Joint Economic Committee, 102d Cong., 2nd Sess. (June 24, 1992) (transcript available from the Joint Economic Committee).

venience, and perceived quality. This, of course, is an incentive for all hospitals to maximize their investment in those areas and thereby drive up their costs.

Hospital behavior often differs from the competitive paradigm in another respect. The competitive model presumes that firms seek to maximize their profits and, concomitantly, that firms with market power (i.e., few competitors) will always use that power to increase prices. Hospitals with market power, however, may be constrained in their ability or willingness to exercise that power. These constraints arise from factors that are in many ways peculiar to the hospital field.

In many cases, a hospital's ability to exercise market power is limited by the fact that its pricing decisions affect a relatively small portion of its business. Medicare, Medicaid, CHAMPUS, and other publicly-sponsored payment programs, for example, set their own payments by regulation. The average hospital receives more than 50 percent of its gross revenues from regulated sources and furnishes a significant portion of uncompensated care. Increases in hospital charges generate no additional revenue from these patients. The ALJ in *In re Adventist Health Systems/West* recognized this fact in his decision:

> [T]he acquisition can have no effect with respect to Medicare, Medi-Cal and no-pay patients, for Ukiah Valley cannot charge prices which exceed the amounts allowed by Medicare and Medi-Cal and receives nothing from no-pay patients.[17]

Price increases also may be ineffective for private payers that have long-term contracts.

Hospitals, while necessarily cognizant of economic considerations, are not mere businesses, any more than educational, religious, public, and other community-based institutions are just businesses. Although the governing boards of all corporations have a fiduciary responsibility to act in the best interest of those corporations, the mission of a community hospital typically is defined in terms of community service and community benefit (including, e.g., the provision of charity care). Most hospitals are governed by local, community-based boards that are attuned to the hospital's mission and recognize that attainment of community objectives may involve actions that are inconsistent with maximizing the hospital's surplus. It therefore cannot be assumed that hospitals will operate identically to traditional commercial enterprises. It is also significant that, in most communities, hospital board membership is heavily representative of local businesses that are major purchasers of health care. These representatives have a specific interest in ensuring that hospital rates are not excessive.

The antitrust laws presume that market forces will eliminate excess capacity from the system. With respect to hospitals, however, the ability of market forces to rationally allocate resources in a socially optimal manner is questionable. Market solutions will take longer to achieve reduction of excess capacity than will collaborative strategies. The faster excess capacity is reduced, the faster the costs associated with excess capacity can be eliminated.

Antitrust policy must also be sensitive to noneconomic priorities in health care. Quality of care may be adversely affected, as economically depressed hospitals can remain in business for some time after quality is compromised. In addition, market forces may not ensure that the right hospitals remain open; hospital closures in underserved areas would exacerbate already serious problems with access to care.

The foregoing factors—the distancing of consumers from the demand for services, the existence of non-price constraints on hospital behavior, and the need to allocate resources in a manner that is socially, not just economically, optimal—provide support for the hospital field's pursuit of collaborative strategies as the most effective way to eliminate excess capacity and reduce costs. Collaborative arrangements provide opportunities to operate services or facilities on a more efficient scale and to convert scarce resources to alternative uses.

THE NEED FOR CHANGE IS WIDELY RECOGNIZED

The AHA is not alone in recognizing the need for flexibility under the antitrust laws as we move toward reform of the health care delivery system. In December 1991, the Advisory Council on Social Security recommended that the Attorney General develop legislation that would permit more hospital mergers.[18] The Council also recommended that the Attorney General and the Secretary of HHS jointly develop

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[17] *In re Adventist Health Systems/West* at 43.

[18] 1991 Advisory Council on Social Security, pp. 126 (Dec. 1991).

legislation to permit two hospitals in the same community to joint venture in order to provide hospital and health-related services.[19]

Last year, the Bush Administration's health care reform program recognized the need to ensure that the antitrust laws do not impede health care reform. The plan urged that "concerns of antitrust liability do not chill the evolution of a more organized and efficient delivery system."[20]

This year, reports indicate that President Clinton's Task Force on National Health Care Reform is considering the need to modify the antitrust laws. As reported recently in the *N.Y. Times* "[c]onfidential work papers from the President's Task Force on National Health Care Reform, headed by Hillary Rodham Clinton, suggest that antitrust laws may need to be modified 'to permit collaborative arrangements' or to change the balance of power between buyers and sellers of health care."[21]

Federal lawmakers have recognized the need for antitrust flexibility as well. Over the past two years, several Members of Congress have introduced legislation that would limit and/or remove the antitrust barriers to certain forms of hospital collaboration. These legislators include Senators Bill Cohen (R–ME) and Orrin Hatch (R–UT), and Representatives Jim Slattery (D–KS), Peter Hoagland (D–NE), Bob Michel (R–IL), Connie Morella (R–MD), and Larry LaRocco (D–ID). All the proposals, in varying ways, seek to address the growing interest in and need to facilitate cooperation among and between hospitals.

Many options are available to encourage collaboration. For example, the AHA is considering an approach that would help lay the groundwork for the formation of networks. This approach, which was conceived before health care reform became a national priority, would establish a voluntary waiver program for hospitals engaged in certain collaborative arrangements to provide health care. Such short-term proposals, however, may be unnecessary if comprehensive health reform appropriately modifies antitrust policy.

AHA's waiver approach is based in part on state statutes that seek, to varying degrees, to protect hospitals' cooperative arrangements from state antitrust laws and to provide "state action immunity" from the federal antitrust laws.[22] Maine, Minnesota, Ohio, Washington, and Wisconsin have already enacted such statutes, and similar bills have been introduced in Colorado, Illinois, Indiana, Kansas, Massachusetts, and North Dakota. Hospitals in at least ten other states have expressed interest in this issue. This growing movement for antitrust reform at the state level confirms that providers and state lawmakers consider the antitrust laws to be significant barriers to cooperative activity that would benefit consumers and purchasers of health care.

CONCLUSION

AHA strongly supports reform of the health care delivery system. In view of the Clinton Administration's—indeed, the entire country's—emphasis on health reform as a top priority, AHA believes that it is necessary to examine antitrust policy within the reform context and eliminate inappropriate barriers to collaboration. While AHA cannot offer a specific legislative solution without knowing the details of the health care reform package to be offered to Congress, it seems that the following issues will need to be considered.

To the extent that networks of hospitals, physicians and other providers are an integral part of reform, the appropriate goal is to encourage competition between the networks. Policymakers will need to consider that some areas, due to geographic location and/or resources, may be unable to support more than one network. In either case, policies that inhibit the formation of networks, or collaboration between providers within a network, are inconsistent with the goals of reform. Finally, formation of efficient networks will necessarily exclude some providers, raising antitrust issues that will need to be addressed.

AHA believes that certain principles undoubtedly must be recognized as part of health care reform.

- Protecting consumer interests is an underlying objective of both the antitrust laws and health care reform. Given this mutual goal, health and antitrust policies should be compatible.

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[19] *Id.* at 126–127.

[20] The President's Comprehensive Health Reform Program, p. 55 (Feb. 6, 1992).

[21] *N.Y. Times,* March 10, 1993 at A1, A8.

[22] The state action doctrine exempts from antitrust scrutiny conduct that is undertaken pursuant to an affirmative state policy reflecting an intent to replace competition with regulation, provided that the conduct is actively supervised by the state.

- The benefits of improved quality and access as a result of provider collaboration must be emphasized.
- Collaboration can result in real cost containment by eliminating excess capacity and unnecessary duplication of equipment and services.
- The special needs of local communities should be paramount. Collaborative efforts to meet local community health needs should be encouraged.
- Greater emphasis should be placed on the potential for efficiencies in hospital markets, particularly given the existing over-capacity and duplication of equipment and services.
- Because hospital markets are inherently concentrated, particularly in less populated areas, less emphasis should be placed upon market concentration.

A clear tension exists between federal antitrust law and collaborative solutions to national health policy concerns. As the country contemplates comprehensive health reform, we need to ensure that innovative ideas for delivering better and more efficient care are not thwarted by the antitrust laws.

Senator METZENBAUM. Dr. Corlin, we are very happy to have you with us this morning. Perhaps you want to introduce the gentleman who is seated to your right.

STATEMENT OF DR. RICHARD F. CORLIN

Dr. CORLIN. Thank you, Senator Metzenbaum. This is Kirk Johnson, who is general counsel of the AMA.

Senator METZENBAUM. We are happy to have both of you with us. Please proceed.

Dr. CORLIN. Thank you, sir. Mr. Chairman and Senator Hatch, my name is Richard Corlin. I am a gastroenterologist from Santa Monica, CA, and vice speaker of the American Medical Association. The AMA appreciates this opportunity to address the antitrust environment and its impact on the evolving health care delivery system. In fact, we believe that antitrust law and enforcement activities must be modified in tandem with the reform of our health care system.

Let me say at the outset that contrary to what you have heard today, the AMA does not seek an exemption from the antitrust laws for physicians. The relief it seeks is limited and is not designed to protect fee for service, but precisely to allow physicians to form integrated ventures and other competitive alternatives. Professor Havighurst is very knowledgeable on antitrust laws, but he does not know what the AMA's policies are, and he plainly does not believe in a diverse medical care market.

Since the 1975 ruling in the *Goldfarb* case, physicians who have attempted to negotiate collectively with third-party payers through a professional organization or a joint marketing venture have at times been subject to criminal investigation and/or civil penalties. While the courts have increasingly come to recognize the unique role of health care providers by applying a more flexible legal standard than either FTC or Justice, the enforcement arm continues to prosecute.

For at least 10 years, Government enforcement agencies and private antitrust counsel have sent physicians a consistent message: collective action by physicians, including legitimate peer review and sorely needed disciplinary actions, carry a high level of anti-

trust risk. Indeed, the mere threat of the antitrust challenge has the most chilling effect imaginable on peer review and self-discipline, and later during questions I have three examples to prove this point that I would like to present to you.

Managed competition will increasingly require physicians to act in a coordinated manner. In order to respond meaningfully, physicians must be able to respond collectively. Although the clarification we seek could be accomplished within the authority of enforcement agencies, statutory action would be an important guarantee to facilitate physician negotiations with managed care plans and other third-party payers, as well as providing consistency to the FTC interpretations and actions, and it is this consistency that is perhaps more important than anything else we seek.

In order to present their views on managed care plans, collective physician input is needed to act as a balance on issues relating to quality of care, program administration, and payment for care provided. From both my point of view as a physician and as a potential patient in need of care, the antitrust laws should not prohibit physicians affiliated with a managed care plan from collectively providing information to the plan on issues ranging from medical review criteria, quality assurance programs, coverage, medical policy, and reimbursement decisions. The AMA recommends that managed care plans establish physician committees to advise plan management on these crucial issues.

We support modification of the Federal antitrust laws for medical self-regulatory entities which are designed to promote the quality of health care. These provisions were included in S. 3348, as introduced in Senator Hatch in the 102d Congress, and in H.R. 47, as introduced by Representative Bill Archer in the 103d Congress.

The current antitrust statutes and enforcement activities severely restrict appropriate professional self-regulation and discipline by the medical community. Most State and county medical societies have committees designed to mediate and resolve patient grievances and to discipline members that engage in unethical conduct. However, these committees have become virtually inactive or underused because of the threat of antitrust challenge. The AMA has filed a petition with the FTC seeking to remove limitations that restrict the medical profession from pursuing efforts to police itself.

In conclusion, health care antitrust relief is needed to permit physicians to address the needs of today and properly respond to the changes we are facing. Appropriate solutions such as those we have recommended will contribute to the success of any model for health system reform that is ultimately adopted.

Mr. Chairman, the AMA appreciates the opportunity to appear before this subcommittee today and we look forward to working with you and Congress to resolve these concerns as health care reform debate intensifies. At this time, I request that my written and oral statements, as well as the AMA's letter send to Chairman Steiger, be submitted for the record.

Finally, I would like to ask that AMA's general counsel, Kirk Johnson, be given permission to make a very brief statement to the committee concerning the AMA's antitrust initiatives and actions. Thank you, sir.

Senator METZENBAUM. We would be glad to hear you, but very briefly.

STATEMENT OF KIRK B. JOHNSON

Mr. JOHNSON. Thank you very much, Senator, and I will be brief. Just for the record on behalf of the AMA, the AMA has not consistently evaded or avoided——

Senator METZENBAUM. Why don't you pull that mike closer to you?

Mr. JOHNSON. Thank you. The AMA has not consistently evaded or avoided the antitrust laws. We are responsible citizens and we obey the laws and we believe in competition. The one Justice Department action against us, Mr. Chairman, was a 1943 case at a very different time in our history in which most medical experts believed paying physicians more to provide less care and denying patients choice was unethical. Those policies have long since changed.

The only action the FTC has brought against us successfully was the 1975 action regarding advertising provisions in our code. It was only in 1971 that it became clear that the professions were subject to the antitrust laws at all, Mr. Chairman, and in 1971 we began to change our code. The provisions in our code that were offensive to the FTC or to the antitrust laws were eliminated at the time the FTC brought the action against us. It elected to proceed nonetheless.

There was not a single example in the FTC case of a time in which the AMA had discouraged, disciplined, or frustrated a physician for making a contract with an HMO or any other alternative delivery system. I have a letter here which we would like to introduce to Chairman Steiger setting that record clear.

[The letter referred to follows:]

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, March, 23, 1993.

Hon. JANET D. STEIGER,
Chairman, Federal Trade Commission,
Washington, DC.

Re: *Role of AMA In Health Care and Antitrust Reform.*

DEAR CHAIRMAN STEIGER: On February 19, 1993, you gave a speech to the National Health Lawyers Association on "The Role of Antitrust Enforcement in Health Care Reform." There is much in your speech with which the American Medical Association agrees. For example, we support your basic point (Speech, p. 1) that "a vigorous antitrust presence is likely to be * * * important to the success of any competition-based model for the health care sector."

Regrettably, however, your speech contains two fundamental mischaracterizations of AMA positions on issues relating to the development of managed care plans and on antitrust developments that may bear on these issues. These are as follows:

(1) You state (at pp. 5–6) that the Commission's 1979 decision in its case against the AMA "freed physicians to enter into contractual relationships with health care plans."

(2) You also state (at pp. 9–11) that physicians attempted ten years ago, and are again attempting, to obtain "special antitrust exemptions for collective action" that would suppress competition in dealing with purchasers of health care services.

This letter will explain why you are mistaken (a) in implying that the AMA opposed the creation of prepaid health care plans in the 1970's and (b) in stating that the FTC's action against the AMA was "necessary to the creation of managed care

plans." This letter will also explain that the AMA has never sought any special exemption from the antitrust laws and that our current proposals are designed only to have those laws applied so as (a) to promote rather than to suppress competition and (b) to permit physician input into decisions that can have major consequences for the well-being of patients.

Preliminarily, let me assure you that the AMA strongly supports reforms that will make health care available to more Americans and that will reduce the costs of such care. At the same time, the AMA believes that care must be taken not to reduce unduly the quality of medical services to patients. We also believe that thoughtful reform of our health care system is most likely to occur if the federal government and the medical profession work together as partners. Speeches which portray the AMA as opposing reform and which try to glorify the FTC at the expense of the medical profession by distorting the facts do not advance this objective and ultimately do no one any good.

There are, of course, always going to be some good faith disagreements between the FTC and the AMA. However, we respectfully submit that these are best addressed by careful analysis and thoughtful discussion. It is in this spirit that we feel compelled to set the record straight on the two points of your NHLA speech raised above.

A. THE AMA DID NOT OPPOSE CONTRACTUAL RELATIONSHIPS BETWEEN PHYSICIANS AND PREPAID HEALTH PLANS IN THE 1970'S, AND THE FTC'S 1979 ORDER AGAINST THE AMA WAS NOT NECESSARY TO THE CREATION OF MANAGED HEALTH CARE PLANS.

Initially, let us acknowledge that the 1971 edition of the *Opinions and Reports of the Judicial Council* of the AMA contained a number of unfortunate statements on contractual arrangements by physicians that had been made in the 1920's and 1930's. These statements, however, did not reflect the post- World War II views of the AMA and were never enforced by the Association. Quite to the contrary, in its only case involving a contractual relationship between a physician and a prepaid health care plan, the Judicial Council stated that the AMA "has long encouraged the development and use of prepaid medical care plans." *Matter of Ben E. Landess, M.D.* (Feb. 9, 1955). The Judicial Council found nothing unethical either in the contractual relationship between a physician and the Health Insurance Plan of Greater New York or in the fact that this managed care plan engaged in advertising.

It was the decision of the Supreme Court in *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975) that provided the impetus for revision of the 1971 edition of the *Opinions and Reports.* As you well know, the Supreme Court held in that case that the professions are subject to the antitrust laws. Within a few months after the *Goldfarb* decision, the process of review of the 1971 edition was begun.

The process culminated in early 1977—over 2½ years before the Commission's Order—when the AMA issued a new edition of the *Opinions and Reports* which deleted all archaic positions on contract practice. The 1977 edition stated only that physicians may ethically be employed on a contract basis but that they "should not be subjected to lay interference on professional matters and that their primary responsibility should be to the patients they serve."

The 1977 edition also contained a statement on advertising by physicians that the AMA had adopted in April of 1976 as part of the post-*Goldfarb* review process. That statement declared that dissemination of fee information and other useful information that will assist patients in making an informed choice among physicians is ethical. Significantly, the statement was issued over one year before the Supreme Court in *Bates* v. *State Bar of Arizona,* 433 U.S. 350 (1977) struck down, by a 5–4 vote, state restrictions on professional advertising. Indeed, the AMA was the first national professional association to support advertising by its members. Its statement was quoted at length by the Supreme Court in *Bates.*

It is noteworthy that in the FTC proceeding, the AMA refused to defend the pre-*Goldfarb* statements on advertising and contract practice contained in the 1971 edition of the *Opinions and Reports.* Instead, we asked the Commission to adjudicate the lawfulness of the positions on advertising and contract practice in the 1977 edition. Nevertheless, the Commission insisted upon predicating liability exclusively on disavowed and undefended statements from the 1971 edition. Significantly, the Commission did not offer a single objection to the AMA's 1977 position on contractual arrangements by physicians.

The only reason that the AMA even litigated the case was that FTC complaint counsel insisted upon the draconian remedy of banning the Association from regulating any advertising by physicians—even false and deceptive advertising. Indeed, the order proposed by the ALJ contained a provision that would have barred the AMA from policing any advertising by its members. This provision was modified by

the Commission to allow the medical profession to regulate deceptive practices by members, 94 F.T.C. 701, 1029, but only after years of costly litigation.

Dissenting from the decision of the Court of Appeals upholding the Commission's Order, 638 F.2d 443 (2d Cir. 1980), Judge Mansfield concluded that the entire FTC proceeding against the AMA was "unjustified, unnecessary, and a waste of administrative and judicial resources." This conclusion was not shared by the two other members of the panel and is, of course, subject to debate. What is certain, however, is that the FTC's 1979 Order against the AMA was not "necessary to the creation of managed care plans." Any AMA-imposed restrictions on the ability of physicians to contract with such plans had ended before 1950, and all vestiges of such restrictions had been voluntarily eliminated well in advance of the Commission's 1979 Order.

B. THE AMA DID NOT SEEK AN EXEMPTION FROM THE ANTITRUST LAWS IN 1982 AND IS NOT SEEKING ONE NOW. THE AMA'S CURRENT PROPOSALS FOR ANTITRUST REFORM ARE DESIGNED TO PROMOTE COMPETITION AND TO PERMIT PHYSICIAN INPUT INTO DECISIONS OF MANAGED CARE PLANS.

I.

Your speech gives the impression that the AMA sought to exempt the medical profession from the antitrust laws in 1982. This is simply not so ! The AMA did at that time seek to eliminate the jurisdiction of the FTC over the medical profession. However, removal of FTC jurisdiction does not even begin to approach exemption from the antitrust laws. Under the AMA's proposal, the profession would have remained subject to antitrust enforcement by the Department of Justice, by private plaintiffs, and by State Attorneys General.

The AMA sought legislation limiting FTC jurisdiction over the professions for several reasons. As you know, the process of the Commission is to issue a complaint, have the case heard by a Commission employee, and then have an appeal to the same Commissioners that issued the complaint in the first instance. This process is much more cumbersome than that followed in antitrust cases in federal court and did not seem fair. It seemed more appropriate and more efficient to have the facts of antitrust disputes found by a neutral federal district court—with initial appeal to an impartial Court of Appeals.

The Commission's process might have been justified if the Commission had some special expertise in health care antitrust matters. However, the Commission's actions in the late 1970's regarding the medical profession did not manifest any special expertise. To the contrary, the Commission showed tremendous hostility to the self-regulatory processes which are a hallmark of the medical profession. This letter has already noted the extremely costly litigation which was necessitated by the position of Commission staff that medical societies should not be allowed to play any role whatsoever in regulating advertising by physicians—regardless of how false or deceptive. Another example of the Commission's hostility to self-regulation was its intervention in the 1970's before the then United States Office of Education to advocate that the profession be stripped of any role in regulating quality medical education.

Although the AMA has endeavored to work cooperatively with the Commission for the last ten years, we are again seeing disturbing signs of Commission hostility to legitimate activities by the medical profession. For example, Commission staff has recently advised the American Academy of Orthopaedic Surgeons that the Academy has violated a consent decree simply by retaining a consultant to restudy the methodology that underlies the Medicare RBRVS and to suggest a different weighting of orthopaedic procedures. Commission staff has taken this position even though the consent decree with the Academy explicitly states that the decree shall not be construed to prohibit the exercise of First Amendment rights.

II.

Your speech also states that the AMA is seeking significant antitrust exemptions now. The fact is, however, that the AMA's proposals for application of the antitrust laws to the health care field do not attempt to immunize the medical profession from antitrust scrutiny. They simply ask that the antitrust laws be enforced with sensitivity to the importance of permitting physicians to provide input to payors on issues relating to the delivery of and payment for care. They also ask that physicians be permitted to form procompetitive joint ventures without fear that those

ventures will be condemned as *per se* unlawful simply because the physicians establish the fees at which their services will be offered.

Specifically, the AMA's first proposal is to clarify that physicians may collectively agree on a proposed reimbursement level to propose to a payer—as long as they do not threaten a boycott if their proposal is rejected. Far from involving an antitrust exemption, this proposal basically would codify existing precedent which recognizes the lawfulness of collective generation and presentation of information by physicians. *See, e.g., United States* v. *Alston,* 974 F.2d 1206, 1214 (9th Cir. 1992). *See also Michigan State Medical Society,* 101 F.T.C. 191 (1981). As the Ninth Circuit recently noted in *Alston,* the antitrust laws do not prohibit health care providers from jointly submitting "a request for an increased fee level" or providing "meaningful input into the setting of the fee schedules."

Our second proposal is to allow physicians without market power to form joint ventures to negotiate contracts with purchasers of medical services regardless of whether the physicians share direct financial risk. These joint marketing ventures can be particularly attractive to self-insured employers who would like to contract directly with a network of physicians without having to involve an insurer or HMO "middleman." In order to function effectively, these ventures must be able to establish a schedule of fees at which the services of participating physicians will be offered. While our proposal contains much detail, its essence is that the pricing and other activities of ventures in which the physicians lack market power should be evaluated under the rule of reason—not condemned as *per se* unlawful. Scrutiny of physician joint ventures under the rule of reason cannot fairly be characterized as an exemption from the antitrust laws.

Our third proposal is that physicians in a community in which there is a payer or coalition of payers with market power should be permitted to form a negotiating group to bargain collectively with the payers. To avoid potential for anticompetitive conduct, the proposal carefully limits any negotiating group to no more than 20 percent of the physicians in the community or in any specialty. We believe that by providing some counterbalance to payer monopsony power, negotiating groups of physicians will help to avoid the distortions of competition that often accompany the exercise of such power—distortions that, in the health care context, can lead to deterioration of quality or reduction in access.

This proposal has been made after considerable thought about the competitive effects of monopsony power and legitimate ways of addressing such effects. It is a good faith attempt to have the antitrust laws deal with monopsony purchasing in health care. The proposal deserves to be debated on the merits—not dismissed by unanalytical incantation of the words "special antitrust exemption."

Finally, our fourth proposal does involve antitrust immunity—but only in the limited circumstances in which physicians affiliated with a managed care plan provide input to the plan but do not threaten a boycott. We believe that this proposal is necessary to encourage physicians to participate in decision-making by managed care plans—just as the Health Care Quality Improvement Act of 1986 was designed to encourage physicians to engage in good faith peer review. In any event, however, this proposal does not involve any wholesale exemption of physicians from the antitrust laws.

CONCLUSION

Our health care delivery system is on the verge of fundamental change. The AMA supports change that will reduce the cost and increase the availability of medical care. We believe that if health care reforms are to work, however, they must be accompanied by modifications in the antitrust laws—or at least in current enforcement policies—to permit a meaningful physician role in negotiations with payers.

For this reason, we have made four very specific and detailed proposals for antitrust reform in health care. We are prepared to discuss and debate those proposals in a thoughtful and constructive manner. We respectfully ask the Federal Trade Commission to do the same and to cease and desist from self-serving misstatements of AMA actions.

Sincerely,

(Signed) James S. Todd, M.D.

(Typed) JAMES S. TODD, M.D.

Mr. JOHNSON. Finally, if I can, Senator, I would just like to say with regard to Professor Havighurst, he has seen one part of our presentation today, but he doesn't know, I don't think, how physicians operate and what they are trying to achieve.

We support integrated entities for physicians, hospitals, and networks. We do believe it is the wave of the future for the profession. It is the way physicians can get control of their lives and their practices and be more efficient and provide better care.

But physicians today predominately practice solo or in small groups. To get to the point of integration, they need an intermediate step, and what we have proposed is that physicians in small groups who want to begin to coordinate, who want to begin to get together, who do not have market power, are allowed to do so. Our proposal is consistent with what the Justice Department has previously said. It could provide economies and it could be a procompetitive venture in the market. We simply want clarification of that today.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Corlin follows:]

PREPARED STATEMENT OF RICHARD F. CORLIN, ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee:

My name is Richard F. Corlin, MD. I am a gastroenterologist in Santa Monica, California and the Vice Speaker of the House of Delegates of the American Medical Association (AMA). AMA General Counsel Kirk B. Johnson, JD, accompanies me today.

The AMA appreciates the opportunity to address this Subcommittee regarding the current antitrust environment and its impact on the health care delivery system, both in its present form, and as it will surely evolve under the health system reform proposals that are now being considered. We believe that the focus on health system reform in the 103rd Congress provides a unique opportunity to take action on a number of viable approaches for improving access to quality medical care. As these options are explored, a reexamination of federal antitrust law and enforcement policy as applied in the health care setting is a necessary component of the debate. To this end, the AMA recommends enactment of legislative initiatives to provide clarification of the antitrust laws so that physicians are able to participate in the system in a way that promotes competition and thereby contributes to the delivery of affordable medical services to all of our citizens. The AMA does *not* seek an exemption from the antitrust laws for physicians.

ANTITRUST AND MANAGED COMPETITION

The major proposals addressing reform of the present health care system contemplate a managed competition model, with managed care plans likely to provide a substantial volume of care. While the specific design of the Administration's plan has yet to be formulated, it is clear that health care providers will be expected to work cooperatively under any new framework to create entities capable of rendering efficient, cost-effective and quality health care.

In order to realize the full potential of the responsibilities that the medical profession will be expected to assume in the emerging health care climate, physicians must be free to negotiate with managed care plans on a variety of issues without the threat of civil or criminal antitrust actions. Managed competition will demand that physicians respond collectively, in order to respond meaningfully. The ability to respond collectively, without engaging in price-fixing, boycotts, or the threat of boycotts, will become increasingly important in enabling physicians to fulfill their historic role as advocates for their patients. Thus, the AMA seeks limited, specific clarification of the antitrust laws and their enforcement to assure that physicians can fulfill the role expected of them in the reform process.

1. The chilling effect of antitrust law in the health care arena

Under traditional antitrust legal analysis and enforcement activities of both the Federal Trade Commission (FTC) and the Department of Justice (DOJ), physicians who have attempted to negotiate collectively with third-party payors through a professional organization or a joint marketing venture have been subjected to criminal investigation and/or civil penalties. These enforcement efforts reflect an unduly restrictive view of the law in light of the relevant federal court decisions. The courts have increasingly come to recognize the unique role of health care providers, and

are, therefore, applying a more flexible legal standard than either the FTC or the DOJ in judging collective activity in the health care arena.

The decision of the Ninth Circuit Court of Appeals in *United States* v. *Alston* [1] reflects this trend. The *Alston* case involved three Tucson, Arizona dentists who were charged with criminal price-fixing for agreeing on a revised schedule of "co-payments" to propose to four prepaid dental plans.[2] No boycott was alleged inasmuch as the dentists continued to provide services to plan patients throughout the negotiation process. The Ninth Circuit noted that health care providers negotiating with payors "face an unusual situation that may legitimate certain collective actions."[3] In particular providers must deal with payors who "act as bargaining agents" for large groups of consumers who dictate "uniform fee schedules—anathema in a normal competitive market."[4] The court found that physicians need to be able "to band together to negotiate" in order to "level the bargaining imbalance."[5] As the court said:

> In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules. Thus health care providers might pool cost data in justifying a request for an increased fee schedule. Providers might also band together to negotiate various other aspects of their relationship with the plans such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such concerted actions, which would not implicate the per se rule, must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals from the plans.[6]

The *Alston* decision clearly demonstrates recognition by the courts of the need to clarify the application of the antitrust laws to physician/payor negotiations. The ruling anticipates an environment in which health care professionals are permitted to advocate their views on how to reduce costs without sacrificing quality. However, under current policy, physicians who engage in conduct such as that described in *Alston,* could reasonably expect to be prosecuted by the Department of Justice, the FTC, and/or private parties. While other courts may also recognize the decision in *Alston,* physicians across the country would fear protracted litigation to vindicate their activities. Procompetitive activities by physicians, such as joint marketing arrangements, should be expressly permitted under the law so that physicians can deliver quality health care in an efficient manner.

For at least ten years, government enforcement agencies and private antitrust counsel have sent physicians a consistent message: collective actions by physicians, whether procompetitive or not, carry a high level of antitrust risk. This advice is not mere conjecture; it is based on a consistent pattern of enforcement by the FTC and the DOJ. A review of recent case law as applied to a number of typical fact patterns reveals the unnecessary antitrust restrictions that are now present in the health care marketplace. (See Attachment A).

2. Legislative solutions

To address the foregoing concerns, the AMA strongly urges clarification of the antitrust laws—not an exemption. Although the clarification we seek could be accomplished without the authority of the enforcement agencies, statutory action would be the most effective solution. A statutory scheme permitting health care providers to join together to collectively negotiate with third-party payors with respect to the operation of a managed care plan, its administrative procedures, and reimbursement schedule will act to promote competition and facilitate meaningful health care reform. In that context, we offer the "Physician-Health Plan Negotiations Act of 1993" which would encourage and facilitate physician negotiations with managed care plans and other third-party payors. (See Attachment B) This model Act would establish safe harbors for physicians who collectively present their views to managed care plans *without engaging in price-fixing, boycotts, or the threat of boycotts.* The Act would also require physician input into administration, coverage and payment policies of managed care plans. Physicians would, therefore, be free to ap-

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[1] 974 F.2d 1206 (9th Cir., 1992).
[2] *Id.* at 1207.
[3] *Id.* at 1214.
[4] *Id.*
[5] *Id.*
[6] *Id.*

proach payors collectively to provide appropriate input on fees and other payment-related issues.

In addition, physicians must be permitted to act on behalf of their patients on issues regarding access to and quality of care. In a managed care setting, physicians can provide both their medical expertise and practical experience in formulating and implementing sound policies. For example, physicians can offer the most salient advice on the appropriate physician to patient ratio in order to provide optimal patient care in particular settings. Where managed care decisions may negatively impact on the quality of patient care, physicians can serve as the strongest advocates of patient interests by recommending other alternatives.

The AMA believes that the antitrust laws should not prohibit physicians affiliated with, but not employed by, a managed care plan from collectively providing information to the plan on such issues as medical review criteria, quality assurance programs, coverage, medical policy and reimbursement decisions. In this context, we present the "Managed Care Improvement Act of 1993," a model Act that would require managed care plans to establish physician committees to advise plan management on medical review criteria, quality assurance issues, grievance mechanisms, and certain financial and administrative matters. (See Attachment B) This model Act would also provide protection for physicians who provide good faith advice and recommendations to a managed care plan. It would further provide antitrust immunity for physicians who in good faith participate in collective activities in developing position statements relating to their relationships with the plan.

In addition, there have been extensive discussions over the years about providing hospitals with some level of antitrust protection so that they can combine to more effectively use expensive health care resources. In developing such legislation, we urge that consideration be given to protection for physicians and other providers who may be locked out of the market when services are combined. If used properly, a combination of community resources will yield cost-effective and practical results. However, such combinations should not be allowed where they are used to selectively exclude practitioners, thereby decreasing competition.

Professional Self-Regulation

The current antitrust statutes and enforcement activities have acted to severely restrict appropriate professional self-regulation and discipline by the medical community as well. Most state and county medical societies have by-laws that provide for standing committees designed to mediate and resolve patient grievances and to discipline members that engage in unethical conduct. Some of the societies hear patient complaints about fees. However, these committees have become inactive or underused in many, if not most, geographic areas. When medical societies have tried to exert their influence on economic matters, antitrust provisions have thwarted their efforts. The AMA has filed a petition with the Federal Trade Commission (See Attachment C) seeking to remove limitations that restrict the medical profession from pursuing additional efforts to police itself. To this end, the AMA also supports H.R. 47, introduced by Representative Bill Archer (R–TX).

In our view, carefully designed immunity from the federal antitrust laws for medical self-regulatory entities engaged in enforcement activities designed to promote the quality of health care, which would be created under H.R. 47 and which were also incorporated into S. 3348, sponsored by Senator Match in the 102nd Congress, would advance progress in a number of areas. Under this type of statutory scheme, standard setting and enforcement activities that would be permitted to flourish without the threat of undue legal sanction would include peer review, technology assessment, risk management, accreditation, and the development and implementation of practice guidelines and ethical codes.

1. Professional peer review of fees

The Federal Trade Commission has issued a number of advisory opinions regarding the operation of professional peer review of fees. These opinions have recognized that properly managed programs can yield procompetitive benefits. The benefits cited by the FTC include an increased flow of information about physician fees to patients, enabling them to compare fees when selecting a physician. Such programs can also act as an inexpensive and efficient method to resolve fee disputes.

In accordance with FTC guidelines, the AMA has filed a petition for an advisory opinion on professional fee peer review. Our program would modify these guidelines, however, to involve mediation of complaints about fees, mandated physician participation, and the ability to discipline physicians for fee gouging. Under this program, state or county medical societies would perform most of the professional review, with the AMA acting as an appellate body for decisions and opinions of the state

societies. This type of enforcement activity would serve to protect patients, increase their confidence in the belief that they will be treated fairly, and facilitate the operation of the market for physician services as well.

2. Health care fraud and abuse

The AMA has undertaken a number of initiatives designed to eliminate health care fraud and abuse. We have participated with the FBI in training agents to ferret out fraud and abuse, established a toll-free hotline so that physicians and medical societies may report fraud, and worked actively with the Federation of State Medical Boards to identify physicians who cross state boundaries to defy the law.

In recent Congressional testimony the AMA urged appropriate application of the antitrust laws to permit information exchange between insurers and to afford immunity to those who provide information in good faith leading to prosecution and conviction of health care offenses. We believe that such an application of antitrust laws would contribute to the elimination of health care fraud and abuse.

CONCLUSION

The AMA strongly recommends changes to the current antitrust environment, particularly as health system reform will dictate the use of new procompetitive approaches for the delivery of affordable medical care. Managed competition will require the incorporation of substantial efficiencies, making cooperation among health care providers and coordinated activity on behalf of patients imperative. Health care antitrust relief will permit physicians to form networks to address the changes that will inevitably occur and provide valuable input into the policymaking activities of managed care plans. Appropriate legislative solutions, such as those we have recommended today, will contribute to the success of any model for health system reform that is ultimately adopted.

The AMA appreciates the opportunity to appear before this Subcommittee. At this time, we will be pleased to respond to questions.

ATTACHMENT A

ANTITRUST OBSTACLES TO PHYSICIAN PARTICIPATION IN PROCOMPETITIVE COLLECTIVE CONDUCT: SOME SPECIFIC EXAMPLES

I.

A group of 100 physicians forms an IPA designed to contract directly with self-insured employee benefit plans. The IPA includes a majority of the members of the medical staff of one of the leading hospitals in town. By contracting directly with the plans, the IPA offers the plans the opportunity to cut out the insurer or HMO middleman, and thereby reduce costs. The IPA also offers broad geographic and specialty coverage—*i.e.,* its member physicians are located throughout the community and practice in all medical specialties. Moreover, the IPA enables the plans to enlist these physicians efficiently by signing a single contract.

Each of the physicians continues to maintain an independent practice outside the IPA. In addition, each of the physicians belongs to a variety of plans outside the IPA. For services performed pursuant to a contract between the IPA and a plan, the physicians are paid directly by the plan on a discounted fee-for-service basis. Payment levels are based on the Medicare fee schedule, adjusted by a percentage negotiated between the individual plan and a consultant of the IPA. The consultant is retained by the IPA's Board of Directors.

The IPA does not submit bills or get paid any amounts by third party payers. Payment flows directly from the payer to the individual physician. The physicians do not share the risk of overutilization. There are no withholds, and to date the IPA has not accepted any prepaid or capitated contracts.

Antitrust Risks: The physicians in the IPA may be charged with criminal or civil price-fixing. Federal antitrust enforcement agencies forbid physicians from agreeing on a fee schedule for an IPA or other joint venture unless the venture is sufficiently "integrated." They have viewed financial risk-sharing as a *sine qua non* of integration. Here, the physicians in the IPA do not directly share financial risk in the sense required by antitrust agencies because the IPA does not charge on a capitated or other prepaid basis. Accordingly, the fee schedule may well be viewed as an illegal agreement on price among competing physicians.

The fact that the IPA uses a consultant, rather than negotiating directly with payers through its Board, is probably irrelevant. The consultant is detained by the Board, and is subject to the Board's ultimate direction. Antitrust officials are likely to view the consultant as an agent of the IPA, who is reaching an agreement on price on behalf of the member physicians.

See, e.g., Arizona v. *Maricopa County Medical Society,* 457 U.S. 332 (1982); *Southank IPA, Inc.,* FTC Docket No. C–3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order); *Preferred Physicians, Inc.,* 110 F.T.C. 157 (1988) (consent order).

II.

Large employers in a mid-sized metropolitan community form a purchasing cooperative to contract for hospital and medical services. Together, the health benefit plans operated by the employers cover 50 percent of the covered lives in the community. In an effort to avoid the inefficiency of negotiating individual contracts with numerous small physician groups, the cooperative wants to enter contracts with a physician network that includes a broad range of geographic and specialty coverage. However, there are no group medical practices of sufficient size to meet the needs of the cooperative's insureds. Accordingly, 150 physicians form an alliance for the purpose of negotiating contracts with the cooperative and any similar purchasing groups that may be formed.

Antitrust Risks: The physicians may be accused of civil or criminal price-fixing, particularly if: (a) the network rejects the offers made by the purchasing cooperative, (b) the physicians are paid on a fee-for-service basis, (c) the network is exclusive—*i.e.,* the physicians do not join other alliances. The antitrust laws may exert significant pressure on the physician alliance to accept the terms offered by the purchasing cooperative. This is so even though the cooperative has significant purchasing power, and even though the alliance was formed to meet the need of the cooperative for a large network of physicians.

See, e.g., Arizona v. *Maricopa County Medical Society,* 457 U.S. 332 (1982); *United States* v. *Alston,* 974 F.2d 1206, 1214 (9th Cir. 1992); *United States* v. *Greater Bridgeport IPA, Inc.,* 7 Trade Reg. Rep. (CCH) para. 50,741 (1992) (DOJ consent order).

III.

A group of 120 physicians in a three-county area forms a "clinic without walls." In essence, the physicians create a multispecialty group practice with numerous locations. Each participating physician's office becomes a separate location for the group practice. Each physician contributes capital to the venture.The venture negotiates contracts with third party payers. Some of the contracts provide for payment on a capitated basis.

Collectively, the physicians represent less than 25 percent of the total physicians in the three-county area. However, in certain specialties (*e.g.,* obstetrics/gynecology and general surgery) the venture includes 65 percent or greater of the physicians in the community.

Antitrust Risks: The formation of the "clinic without walls" may be challenged under section 7 of the Clayton Act. Antitrust officials have repeatedly stated that, in analyzing the market power of joint ventures involving physicians, they will look not only at the venture's share of the total physician market (here, less than 25 percent) but also its share of relevant medical specialty markets. Because this venture includes a relatively high market share with respect to certain specialties, the venture could be subject to liability or forced dissolution.

See, e.g., Address by James F. Rill to the National Health Lawyers Association (Feb. 15, 1991).

IV.

A medical specialty society contracts with an independent consulting firm to "restudy" the relative values developed by HCFA for payment of certain medical procedure codes under the Medicare RBRVS. The consulting firm collects data by surveying physicians concerning the amount of time and work involved in these medical procedures. It follows the same basic survey method that HCFA used in developing its relative values, with some changes to correct perceived methodological flaws in the HCFA approach.

The consulting firm then analyzes the data, and develops a list of suggested relative work units involved in various procedures. These work units are a critical component of an RBRVS. Some of the work units are lower than those developed by HCFA, but most of them are higher. The consulting firm also supplies a written report explaining why it believes that its relative work units are more accurate and defensible than those developed by HCFA.

The specialty society reviews the consulting firm's findings and decides to "endorse" the study. Specifically, the specialty society sends the study out to HCFA and to other governmental and private third party payers. Private payers are included on the list because many of them are considering use of the Medicare fee schedule as the basis for their own payment schedules. The specialty society includes a cover letter asking that the payer carefully consider the consulting firm's findings.

The specialty society also provides the study (including its list of relative work units) to individual members of the society who request a copy. All members are made aware of the existence of the study (through society newsletters, etc.), but they are not routinely sent a copy.

Antitrust Risks: In the late 1970's and early 1980's, the Federal Trade Commission obtained several consent decrees against medical societies that had developed relative value scales. The Commission apparently continues to believe that these activities raise a serious risk of anti-competitive effects. The Compliance Division of its Bureau of Competition has taken the position that a restudy by the American Academy of Orthopaedic Surgeons to critique the Medicare RBRVS violates a consent decree prohibiting the Academy from developing relative value schedules. On the Commission's reasoning, moreover, efforts to question the Medicare RBRVS may be viewed as price-fixing.

See, e.g., American Academy of Orthopaedic Surgeons, FTC Docket No. C–2856; *American Society of Internal Medicine,* 105 F.T.C. 505 (1985); *See contra, United States* v. *American Society of Anesthesiology,* 473 F. Supp. 147 (S.D.N.Y. 1979).

ATTACHMENT B

THE AMERICAN MEDICAL ASSOCIATION

PHYSICIAN NEGOTIATIONS WITH THIRD PARTY PAYERS: PROPOSALS FOR ANTITRUST REFORM

In the last decade, the economics of health care delivery in America have changed dramatically. Health care markets today are characterized by large managed care plans that are taking aggressive actions to reduce their costs. Some cost-cutting is, of course, not only appropriate but desirable. However, excessive concern for costs can curtail the availability of medically appropriate services to patients and diminish the quality of those services. For this reason, our society should encourage active input to payers from physicians who are concerned about the availability and quality of medical services for patients.

Current legislative proposals for health care reform are designed to enable payers to exercise even greater bargaining power. At the same time, these proposals appear to assume that physicians will have a significant role to play in shaping policy under a revamped health system. In this regard, the proposals follow the approach to health care payment and delivery that has been adopted in other major industrialized nations such as Germany, France, Canada, and Australia. These countries each include a structured role for physician negotiations as a critical feature of their health care delivery systems.[1]

By contrast, federal antitrust enforcers are taking the position that physicians who join together to negotiate with insurers and other third party payers over reimbursement issues violate the antitrust laws. Dozens of physicians who have participated in joint negotiations have been subjected to criminal investigations. Others have been exposed to substantial civil penalties. Countless others have been deterred from engaging in negotiations with payers by the threat of antitrust sanctions.

The American Medical Association ("AMA") believes that federal antitrust policy is on a collision course with health care reform. If reform is to succeed in ensuring access to high quality, affordable health care for all Americans, physicians must

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[1] *See, e.g.,* United States General Accounting Office, *Health Care Spending Control: The Experience of France, Germany, and Japan* 34 (1991); W. Glaser, *Health Insurance in Practice* 251–52, 485–87 (1991); W. Glaser, *Health Insurance Bargaining* (1978).

have a strong, collective voice on issues relating to the delivery of and payment for care. As the United States Court of Appeals in San Francisco recently observed, health care providers must be permitted to act collectively to "level the bargaining imbalance" created by payers.[2] In particular, providers should be able to "band together to negotiate" with payers regarding the operation of a plan, its administrative procedures, and its reimbursement schedule.[3]

Under the antitrust laws as currently interpreted and enforced, however, physicians who engage in collective negotiations are threatened with criminal prosecution or costly civil litigation. This state of affairs is unacceptable as a matter of health care policy, proper antitrust analysis, and fundamental fairness. Antitrust reform in health care therefore is an issue that demands immediate attention.

In this paper, the AMA sets forth several specific proposals that are intended to promote competition while facilitating meaningful health care reform. In particular, this paper explains why:

(1) Physicians acting through their medical society or other professional group should be permitted to agree on a reimbursement level to propose to a third party payer;

(2) Physicians should be permitted to form joint marketing networks to negotiate contracts with employers and other purchasers of medical services, whether or not the physicians share direct financial risk;

(3) Physicians who practice in a community in which there is a powerful payer or coalition of payers should be permitted to form negotiating groups of reasonable size to bargain collectively with the payer; and

(4) Physicians who are affiliated with a managed care plan should be encouraged to provide their good faith, collective input to the plan on such topics as coverage decisions, quality assurance matters, and administrative and reimbursement issues—without fear of antitrust liability.

These proposals can be implemented through changes in current enforcement policy. As a practical matter, however, legislative action may be necessary in order to effectuate them. Accordingly, a model statute embodying proposals 1–3 is attached as Appendix A. A model statute embodying proposal 4 is attached as Appendix B.

Background

The Context for Antitrust Reform

When physicians join together to negotiate with a payer, their conduct often takes one of two forms. In the first situation, physicians in independent medical practice offer their services to managed care plans and other third party payers. They may approach a payer to propose specific reimbursement levels for particular medical services. Physicians affiliated with a particular medical plan may also wish to express their concerns about coverage, utilization, administrative, and financial decisions of the plan that have a direct impact on the practice of medicine. Often, the physicians act through their medical society or other professional group, but in many instances, would like to work directly with managed care plans with which they are affiliated.

In the second situation, independently practicing physicians compete with managed care plans. They may form an entity to market their services jointly to employers or other purchasers of medical services. The physicians offer a variety of services valuable to payers and patients such as utilization review, quality assurance, and joint billing. They also develop a schedule of discounted fees. However, the physicians do not actually merge their practices.

Antitrust officials in the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ") consider negotiations of fees in both contexts to be *per se* violations of the antitrust laws—*i.e.*, activities that must be condemned without any significant analysis of their effects on competition. Accordingly, the agencies have aggressively pursued physicians who have attempted to negotiate fees with payers either through a professional organization[4] or through a joint marketing venture.[5]

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[2] *See United States* v. *Alston*, 974 F.2d 1206, 1214 (9th Cir. 1992).

[3] *Id.*

[4] *See, e.g., United States* v. *Alston, supra*, 974 F.2d 1206; *United States* v. *Burstiner*, 1991–1 Trade Cas. (CCH) para. 69,422 (1991) (consent order); *United States* v. *Massachusetts Allergy Society*, 1992 Trade Cas. (CCH) para. 69,846 (1992) (consent order).

[5] *See, e.g., Southbank IPA, Inc.*, FTC Docket No. C–3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order); *Preferred Physicians, Inc.*, 110 F.T.C. 157 (1988) (consent order); *United*

Speeches and public statements by antitrust officials have reinforced the message that physicians who approach payers collectively will face serious antitrust risks.[6]

Ironically, during the same period, the FTC and DOJ have shown a highly permissive attitude toward the conduct of third party payers. This is so even though some payers represent powerful corporate entities with significant market power.[7] Indeed, the leniency of these agencies towards payer conduct has not been limited to the unilateral activities of a single payer. The FTC and DOJ have also declined to take action against coalitions of health care purchasers who join together for the express purpose of exercising bargaining leverage in negotiations with individual providers.[8]

The result of these enforcement policies is a grossly uneven playing field in the market for medical services. Physicians have been deterred from engaging in conduct that promotes competition and helps patients. At the same time, there is a near complete absence of antitrust supervision of the practices of third party payers.

Instead of protecting competition in health care, federal antitrust policy has had the perverse effect of tilting the competitive balance in favor of large payers and against independently practicing physicians and their patients. The need for change is made even more acute by the growing consensus that the health care system is itself in critical need of repair. It is often said that the antitrust laws are designed to serve as a "consumer welfare prescription."[9] If that is so, the FTC and the DOJ are prescribing the wrong medicine.

Specific Proposals

I. The Antitrust Laws Should Not Prohibit Physicians From Agreeing On Reimbursement Levels To Propose To A Third Party Payer

The AMA's first proposal is that physicians should be permitted to agree on reimbursement levels to suggest to a third party payer. Physicians have long sought to make their views known on reimbursement matters to third party payers. Among the topics that physicians address in communications with payers are whether reimbursement levels are appropriate, whether a particular service should be covered, and whether particular administrative practices of the payer are sound. Often, the physicians speak through their medical society, which has the resources and expertise on medical and economic issues to develop and present useful data.

A.

Absent a boycott or threat of boycott by the physicians, physician input on reimbursement issues may have substantial procompetitive benefits. It is axiomatic that health care markets suffer from a chronic deficiency of information.[10] The information that patients and payers most need is frequently within the collective expertise of the medical profession. For example, whether an insurer should pay for a particular medical service may depend on whether the service is deemed "medically necessary" within the terms of the insurer's policy.[11] That issue cannot be meaningfully addressed without the input of practicing physicians.

States v. *Greater Bridgeport IPA, Inc.*, 7 Trade Reg. Rep. (CCH) para. 50,741 (1992) (proposed consent order).

[6] *See, e.g.*, "Health Care Cost Containment and Competition," Address by James F. Rill, Assistant Attorney General, Antitrust Division, Dept. of Justice (April 23, 1991); "Antitrust Enforcement in the Health Care Field: A Report from the Department of Justice," Address by Robert E. Bloch, Chief, Professions and Intellectual Property Section, Antitrust Division, Dept. of Justice (Feb. 15, 1991).

[7] *See* M. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237, 242–43 (1989); *Kartell* v. *Blue Shield of Massachusetts*, 749 F.2d 922, 924 (1st Cir. 1984) (Blue Shield provides health insurance coverage for 74 percent of Massachusetts residents who privately insure against health costs).

[8] *See* "Group Buying and Antitrust," Address by Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission (April 2, 1992); "Health Care and Antitrust Enforcement: The Buyer's Eye View," Address by Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Department of Justice (February 28, 1989).

[9] *Reiter* v. *Sonotone Corp.* 442 U.S. 330, 343 (1979) (quoting R. Bork, *The Antitrust Paradox* 66 (1978)).

[10] *See, e.g.*, K. Arrow, *Uncertainty and the Welfare Economics of Medicare Care*, 53 Am. Econ. Rev. 941 (1970); M. Pauly, *Is Medical Care Different?*, in *Competition in the Health Care Sector: Past Present and Future* 11 (W. Greenburg ed. 1978).

[11] *See generally* Annot., *What Services, Equipment, or Supplies are "Medically Necessary" for Purposes of Coverage Under Medical Insurance*, 75 A.L.R. 4th 763 (1990). Moreover, an insurer's

Continued

Payers also need information from practicing physicians regarding the appropriateness of fee levels. In most payment plans, the payer must determine fee levels for thousands of medical services.[12] To do so, the payer must consider not only the historical charges of individual physicians, but also the costs that physicians incur in providing each type of service. In order to determine whether the benefits of a service justify its costs, the payer must also evaluate clinical information regarding the efficacy of particular services. Physicians acting through their medical societies or other groups are uniquely capable of contributing information that may assist payers to make these determinations.[13]

By approaching a payer collectively, through a medical society or other professional group, physicians can achieve economies in the production and dissemination of information that would otherwise be unattainable. Medical societies often possess both the resources and the expertise to gather and meaningfully analyze fee-related data. By contrast, an individual physician does not have the time or resources to develop a picture of conditions across an entire segment of the profession. Although it is possible for each payer to collect such information from individual physicians, such an approach is costly and time-consuming and may compromise the accuracy of the data received. It is far more efficient for payers to collect this information from professional groups.[14]

Suppose, for example, that a new medical procedure is developed to examine cells for cervical cancer. When the test first comes into use, payers may lack information concerning the circumstances in which the test should be performed, the amount of time that it takes, and the costs that it involves. As a result, a payer may establish a fee that does not adequately take these considerations into account. Over time, even if the physicians do not collectively make their views known, the payer may learn through trial and error how to adjust its fees. But trial and error is costly, both in human and economic terms. While the payer is learning the market, some patients may fail to receive timely testing.

Efficiency is promoted when physicians who perform the test can join together and provide the payer with information about the test, its costs and benefits, and the fee that the physicians view as reasonable. If the physicians make a compelling presentation, fees will be adjusted in their favor. If the payer is not persuaded, fees will stay the same or be reduced. Competition will not be harmed in either event.[15] Under current policy, however, physicians cannot approach the payer collectively to make a fee proposal without significant antitrust risk.

In this regard, it should be noted that an agreement by physicians on a fee proposal does not raise the same potential for harm to competition that ordinarily arises when competitors reach an agreement related to price. Unlike typical sellers, physicians generally have little or no direct control over the amounts they are paid. Particularly in the managed care context, they are "price takers" rather than "price makers." Thus, when a group of physicians agrees on a fee proposal to make to a payer, the agreement has no direct economic effect: It influences prices only to the extent that the payer chooses to adopt the proposal. Competition is not harmed unless the physicians engage in a boycott or other coercive conduct that effectively forces the payer to raise its fees.[16]

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decision whether to provide coverage may have liability implications for the treating physician. *See, e.g., Wickline* v. *State of California*, ?83 Cal. App. 1064, 228 Cal. Rptr. 661 (Cal. App. 1986).

[12] *See Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 139 (1982) (Rehnquist, J., dissenting on other grounds) ("Insurance claimants seek reimbursement for virtually every form of medical treatment and care, and determining the reasonableness and necessity of such expenses requires the expertise of a practicing physician.").

[13] The development of Medicare's new "resource-based relative value scale" ("RBRVS") system of payment illustrates the contributions that physicians, acting collectively, can make on reimbursement issues. In developing the RBRVS, Medicare officials and Congress recognized that physician involvement was essential. *See* 42 U.S.C. sec. 1395w–4(c)(2)(A)(ii). The Department of Health and Human Services ("HHS") therefore convened consulting panels of physicians in each medical specialty to provide necessary clinical and reimbursement-related information. Although the RBRVS went into effect a year ago, HHS is continuing to consult with professional organizations in an effort to develop a workable payment system. Moreover, HHS officials have indicated that they will continue to do so in the future.

[14] *See* F. Easterbrook, *Maximum Price Fixing*, 48 U. Chi. L. Rev. 886, 898 (1981).

[15] It should go without saying that a fee increase that results from a purchaser's unilateral, informed decision is not anticompetitive. *See* R. Posner, *Information and Antitrust*, 67 Geo. L.J. 1187 (1989).

[16] *See Schachar* v. *American Academy of Ophthalmology*, 870 F.2d 397, 400 (7th Cir. 1989) (when medical society "provides information * * * but does not constrain others to follow its recommendations, it does not violate the antitrust laws."); *Virginia Academy of Clinical Psychologists* v. *Blue Shield of Virginia*, 624 F.2d 476, 483 (4th Cir. 1980) (not illegal for medical society "to make recommendations aimed at persuading Blue Shield to adopt its proposal and use its services, absent some form of coercion.").

To be sure, there is the potential for anticompetitive behavior when physicians join together to negotiate fees with a payer. The physicians must continue to make individual decisions regarding participation in the payer's plan. A mass campaign of departicipation designed to coerce a payer to increase its fees would be properly treated as an unlawful group boycott. But boycotts can be detected and sanctioned without forbidding every collective effort by physicians to make their views on fee-related issues known to a payer.

In theory, there is also some risk that an agreement among physicians to propose a reimbursement level to a payer could "spill over" into an agreement on the fees that the physicians charge in their individual medical practices. But the risk is remote. Such a spill-over effect has never been documented in any litigated case or economic study.[17] Moreover, with the growing prevalence of managed care, it is becoming increasingly unlikely that such a spill-over could occur. A physician who is merely a "price taker" can propose, but has no power to implement, an agreed-upon fee level.

B.

Despite the strong potential for procompetitive benefits from physician negotiations with third party payers, the FTC and DOJ have viewed nearly all collective presentations to payers relating to reimbursement as inherently suspect. The most recent example is the price fixing prosecution of three Tucson dentists and their professional corporations in *United States* v. *Alston*.[18]

Alston involved approximately fifty dentists in Tucson, Arizona who agreed on a revised schedule of "co-payments" to propose to four prepaid dental plans.[19] The dentists also sent identical letters to the plans presenting their proposed schedule and the reasons why it should be adopted. Subsequently, the plans raised their co-payments to the level proposed by the dentists. The DOJ prosecuted the dentists on the theory that they had fixed prices by agreeing on a specific increased fee level to propose to the plans. Notably, the DOJ did not allege a boycott: It was undisputed that the dentists had continued to provide services to plan patients throughout the period of negotiations.

In its opinion, the Ninth Circuit makes several important observations about provider-payer negotiations. The court notes that health care providers faced an "unusual situation that may legitimate certain collective actions."[20] In particular, providers must deal with payers who "act as bargaining agents" for large groups of consumers and who "use the clout of their consumer base to drive down health care service fees."[21] Further, fees are often set not by the provider but by the payer, according to uniform fee schedules. The court found that:

> In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules. Thus health care providers might pool cost data in justifying a request for an increased fee schedule. Providers might also band together to negotiate various other aspects of their relationship with the plans such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such concerted actions, which would not implicate the per se rule, must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals from the plans.[22]

The Ninth's Circuit's opinion does not resolve the question whether the dentists' conduct violated the antitrust laws.[23] Nevertheless, its analysis points the way to

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[17] The FTC has noted the possibility of spill-over as a theoretical matter only. *See American Society of Internal Medicine,* 105 F.T.C. 505 (1985) (advisory opinion) (stating that physician agreement on relative value scale might spill over into physicians' individual medical practices).

[18] 974 F.2d 1206 (9th Cir. 1992).

[19] The plans paid participating dentists a capitation fee for each patient, and permitted the dentists to charge an additional co-payment for certain more complex procedures such as root canals. *Id.* at 1207. "The plans, not the dentists, determine[d] both fee amounts." *Id.*

[20] *Id.* at 1214.

[21] *Id.*

[22] *Id.* (citation omitted).

[23] The appellate court found that there was a factual dispute as to whether the dentists believed that the plans wanted them to submit a fee proposal. *Id.* at 1208 n.2, 1213. Accordingly, the case was remanded to the district court for a possible new trial.

a correct resolution of the antitrust issue. Contrary to the position urged upon the court by the DOJ, the opinion expressly endorses the view that health care providers may "band together to negotiate" fees and other aspects of their relationship with payers. In particular, providers may submit "a request for an increased fee level" and may join together to "provide meaningful input into the setting of the fee schedules."[24]

Alston demonstrates the need for reconsideration of the application of the antitrust laws to physician-payer negotiations. Physicians and other health care providers should not be exposed to the "crushing consequences" of a criminal prosecution for engaging in conduct that is arguably procompetitive.[25] Criminal sanctions should be reserved for conduct that is clearly anticompetitive and that a defendant knows is wrong.[26] Under that test, the actions of the Tucson dentists do not warrant prosecution. Theirs was an open and overt campaign to persuade the plans that co-payment fees were inadequate. The plans acted to raise fees because the dentists made their case.[27]

The AMA calls upon antitrust officials to issue a clear statement that physicians are free to approach payers collectively in order to provide input on fees and other payment-related issues, absent a boycott or threat of boycott. The AMA will also seek legislation along the lines of the Physician-Health Plan Negotiations Act (Appendix A) to establish a "safe harbor" for physicians who present their views collectively to payers without engaging in price fixing or a boycott. Otherwise, health care providers will be deterred from engaging in useful and potentially procompetitive activities.

II. THE ANTITRUST LAWS SHOULD NOT PROHIBIT PHYSICIANS FROM FORMING JOINT MARKETING NETWORKS TO NEGOTIATE DIRECT CONTRACTS WITH PURCHASERS OF MEDICAL SERVICES

The AMA's second proposal is that physicians should be permitted to form joint marketing networks for the purpose of negotiating contracts with employers and other purchasers of medical services. Under current enforcement policy, physicians who form such a network may not establish a fee schedule for the network unless they accept pre-paid, capitated fees or otherwise share an insurance-type risk. This policy is inhibiting the formation and operation of procompetitive ventures that can lower the cost and increase the quality of health care.

A.

The majority of physicians in the United States today are self-employed and practice in small, independent medical offices.[28] In recent years, many independent physicians have been looking for ways to maintain or increase their patient base without altering the basic structure of their practice. One approach has been to form an independent practice association, or "IPA."

An IPA is an organization of independently practicing physicians who act as a single entity for purposes of obtaining contracts with purchasers of medical services. By acting together, the physicians in an IPA can offer a package of services that none of them could offer individually. In particular, an IPA can offer a full range of medical specialty services, widespread geographic coverage, and a high level of physician capacity. In addition, an IPA often provides centralized billing and administration, quality assurance, utilization review, practice profiling, and other services.

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[24] As additional examples of conduct that "would escape the per se rule and might be perfectly legal under the rule of reason," the Ninth Circuit cited: "dentists commiserating over the low fee schedules; or impugning the motivations or integrity of the plans; even sabre-rattling about economic retribution at some indefinite time in the future if their grievances remain unaddressed." *Id.* at 1214. The court further noted that "[s]ome such activity * * * would even be constitutionally protected." *Id.*

[25] *Id.*

[26] *See United States* v. *United States Gypsum Co.*, 438 U.S. 422, 442 (1978) (criminal sanctions under Sherman Act should be limited to "conscious and calculated wrongdoing" and should not be used to "regulate business practices regardless of the intent with which they were undertaken.").

[27] As the Ninth Circuit noted, the co-payment levels in Tucson had not been increased in ten years. 974 F.2d at 1207. Through the negotiations, the dentists obtained an increase to the level permitted by plans in Phoenix.

[28] American Medical Association, Center for Health Policy Research, *Physician Marketplace Statistics—1991* 109–10.

Sometimes, the IPA works together with a hospital to offer an even broader package of services.[29]

The IPA structure is particularly attractive to self-insured employers who are looking for a network of physicians to provide care to their employees.[30] By contracting directly with the IPA—rather than through an insurance company or HMO—the employer can significantly reduce its costs in two respects. First, the employer reduces its search costs by obtaining access to a network of high quality, discounted-fee providers—without having to assemble its own panel. Second, the employer reduces costs by eliminating the insurer or HMO "middleman."

In order for the IPA to function, however, it must be able to establish prices for the services of its members. This can be done in a number of ways. One option is for the physicians to agree to accept a fixed, prepaid amount and to function, in effect, as an HMO. Alternatively, the physicians may prefer to provide services on a fee-for-service basis under a schedule of discounted fees. Under either approach, the expectation of increased patient volume enables the physicians to offer lower fees than they might otherwise offer.

The physicians' agreement on fees for the IPA may be price fixing in the literal sense, but it is not the type of price fixing that the antitrust laws are designed to prevent. The establishment of a price is essential to the marketing of the IPA.[31] As long as the IPA is not so large as to possess market power, the physicians will have every incentive to reduce their fees so that payers will want to contract with them. If the physicians do not lower their fees, payers will seek contracts from other physicians or physician groups.

Only if the physicians participating in the IPA collectively possess market power could the IPA be used as a vehicle for suppressing competition and driving up fees. Without market power, an IPA that fails to offer attractive fees will simply not stay in business.

B.

Both the FTC and the DOJ have spoken out strongly against the formation of what they refer to as "sham IPA's."[32] The agencies place in this category any IPA that establishes fees but that does not involve substantial economic "integration" among the physician members. An essential feature of integration, in the view of antitrust officials, is direct financial risk-sharing among members of the IPA. Absent such integration, the FTC and DOJ consider joint pricing by the physician members of the IPA to be *per se* illegal.

For example, in the FTC's *Southbank* case,[33] the Commission obtained a consent decree against an IPA formed by several obstetrician-gynecologists in the Jacksonville, Florida area. The IPA had collectively marketed its services to payers based on a discounted fee for service payment schedule. It also offered ancillary services such as quality assurance and utilization review. The Commission's consent decree required the dissolution of the IPA, on the theory that the physicians' establishment of a fee schedule constituted price fixing.

In addition, the consent decree prohibited the individual physicians from engaging in other joint arrangements unless those arrangements qualified as an "integrated joint venture." The consent decree defined an "integrated joint venture" as an arrangement in which:

> * * * physicians who would otherwise be competitors pool their capital to finance the venture, by themselves or together with others, *and share substantial risk of adverse financial results caused by unexpectedly high utilization or costs of health care services.*[34]

The agencies have also used this definition in other enforcement proceedings and in informal statements of policy.[35]

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[29] *See, e.g.,* J. Johnsson, "Direct Contracting: Employers Look to Hospital-Physician Partnerships to Control Costs," *Hospitals* (Feb. 20, 1992), at 56.

[30] *See, e.g.,* P. Kenkel, "Taking the Direct Approach," *Modern Healthcare* (March 16, 1992), at 45.

[31] *See Broadcast Music Inc.* v. *Columbia Broadcasting System,* 441 U.S. 1 (1979) (*"BMI"*).

[32] *See, e.g.,* "Antitrust Perspectives On Joint Ventures Among Health Care Providers," Address by Mark Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission (August 11, 1992).

[33] *Southbank IPA, Inc.,* FTC Docket No. C–3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order).

[34] *Id.* at 2914 (emphasis added).

[35] *See, e.g., Preferred Physicians, Inc.,* 110 F.T.C. 157 (1988) (consent order).

The *Southbank* definition of "integrated joint venture" deters the formation of IPA's and other procompetitive physician joint ventures. Under the *Southbank* definition, an IPA will not qualify as an "integrated joint venture" if it accepts payment on a fee-for-service basis. Instead, the IPA must agree to accept fixed, capitated fees—thus becoming, in effect, an HMO that both provides services and insures against excess utilization. In order to calculate capitated fees, the IPA must have access to actuarial data used by insurance companies. But physicians do not ordinarily have access to this sort of information, and acquiring it can be costly.

The most significant problem with the *Southbank* approach is that it fails to recognize that IPA's can offer significant efficiencies even without financial risk-sharing. Efficiencies are gained from joint billing, utilization review, quality assurance, adherence to practice guidelines, and the like. Further, by including physicians from throughout a payer's service area, an IPA can offer payers a "new product" that no individual physician could offer—*i.e.,* a panel of physicians available to provide services to all of the payer's insureds or enrollees.[36] Indeed, a former chief of the Antitrust Division has recognized the "substantial procompetitive benefits" that may be achieved through "integration that falls short of financial participation and sharing of risks":

> For example, integrative efficiencies can be realized through an agreement among physicians to give up some of their freedom in setting the terms of billing and treatment in order to reduce transaction costs and to offer discount fee levels. In addition, provider-controlled PPO's may jointly market their venture to insurers or small employers unable to organize their own panels. In both cases, PPO's can generate procompetitive benefits despite the fact that financial risk is not shared.[37]

Contrary to the assertions of antitrust officials, the *Southbank* approach is not required by the Supreme Court's decision in *Arizona* v. *Maricopa County Medical Society*.[38] *Maricopa* involved the development of a fee schedule by a medical foundation consisting of 70 percent of the physicians in the Phoenix area. The Court specifically found that the foundation had "substantial power in the market for medical services."[39] By contrast, the agencies' current approach condemns any "unintegrated" venture in which physicians agree on a fee schedule, regardless of the venture's size.[40]

In considering the lawfulness of physician joint ventures such as IPA's, the FTC and DOJ should focus on the size of the IPA and the nature of the efficiencies that it offers, rather than demanding the sharing of an insurance-type risk. Without market power, an IPA cannot coerce any payer into dealing with it and therefore cannot harm competition. Further, an IPA that is limited in size has a strong incentive to exercise selectivity—*i.e.,* to choose the highest quality physicians that it can obtain at the desired fee level. The physicians in the IPA therefore share incentives to control utilization and costs, even without acting as insurers.

An IPA is a "sham" only if it offers no significant efficiencies. But efficiencies can be gained from joint activities other than direct financial risk-sharing through the acceptance of fixed, capitated fees. Indeed, physicians who commit to a joint program of cost containment do share risk, even if they are paid on a fee-for-service basis. For the venture to be successful, the physicians must each provide services on a cost-effective basis. A failure to do so will reflect poorly not only on the venture, but also on the individual physicians.

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[36] *Cf. BMI, supra,* 441 U.S. at 21–23.

[37] "Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation," Address by Charles F. Rule, Assistant Attorney General, Antitrust Division, Department of Justice (March 11, 1988), at 12–13.

[38] 457 U.S. 332 (1982).

[39] *Id.* at 354 n.29.

[40] To be sure, the Court in *Maricopa* did use language similar to the *Southbank* definition of "integrated joint venture" at one point in its opinion. Specifically, the Court distinguished a medical foundation established by "hundreds of competing doctors" from "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit." 457 U.S. at 356. But this *dictum* does not require financial risksharing as a prerequisite to legality. Rather, it merely sets forth one example of a type of venture that would plainly be lawful.

It is questionable whether *Maricopa* would be decided the same way today. *Maricopa* was decided by a sharply divided (4–3) Court, with Justices Blackmun and O'Connor not participating. Justice Powell wrote a strong dissent arguing that the physicians' agreement on a fee schedule was comparable to the agreement on prices upheld in *BMI*. Interestingly, the Ninth Circuit panel that the Supreme Court reversed included Judge, now Justice, Kennedy. *See* 643 F.2d 553.

Once again, this issue could be addressed by an unequivocal public statement by antitrust enforcement agencies that they will not take action against physicians who are attempting to compete by creating procompetitive joint ventures, regardless of whether direct financial risk-sharing is involved. However, given the uncertainty engendered by previous enforcement actions, the AMA believes that legislative action may be necessary.

Specifically, the AMA is proposing in the legislation set forth in Appendix A that physician networks that meet appropriate qualifications should be free to establish fee schedules in order to market their services to employers and other third party payers. To qualify for such treatment, the network should include no more than 20 percent of the total number of physicians, or of the physicians from a particular specialty, in a relevant geographic area.[41] In addition, the network should have at least three of the following efficiency-enhancing characteristics:

- The network follows a quality assurance program that regularly reviews the services provided by IPA members;
- network members adhere to a defined set of practice parameters;
- the network employs practice profiling, outcomes research or similar techniques to evaluate, critique and improve the performance of its members.
- the network is responsible for billing and collecting fees for the services of members;
- network members contribute a pro rata portion of the network's total equity capitalization;
- network members share the risk of overutilization of services, through capitation payments or withholding of a percentage of payments.

Physician networks that meet the 20 percent rule and satisfy at least three of these criteria should be permitted to engage in joint pricing and negotiations without fear of liability under section 1 of the Sherman Act or section 5 of the FTC Act. Networks that fall short of the statutory criteria should generally be analyzed under the rule of reason. Only those networks that involve physicians with market power who have engaged in no significant integration of their practices—but who nevertheless agree on prices—should be treated as unlawful *per se*.

III. THE ANTITRUST LAWS SHOULD NOT PROHIBIT PHYSICIANS FROM FORMING NEGOTIATING GROUPS OF REASONABLE SIZE TO BARGAIN COLLECTIVELY WITH MARKET DOMINANT PAYERS

The AMA's third proposal is that physicians in a community in which there is a payer or coalition of payers with market power should be permitted to form a negotiating group to bargain collectively with the payer. The AMA proposes that the negotiating group be limited in size to no more than a fixed percentage—for example, 20 percent—of the physicians in the community or in any specialty.

A.

The issue of buyer-side market power in health care is a timely and important one. Already, in many states, the market for health insurance and other forms of health care financing is dominated by a single large payer such as a Blue Cross and Blue Shield plan.[42] Typically, in addition to a dominant payer, there are many smaller payers such as self-insured health benefits plans offered by employers.

Current proposals for health care reform, if enacted, are likely to result in a significant increase in concentration in health care financing markets. For example, the "single payer" or "Canadian system" approach calls for a single monopsonistic

[41] In this regard, the draft legislation provides that the percentage of physician participation in a health plan should be determined by including in the numerator the number of physicians who participate in the network, and including in the denominator the sum of the total number of physicians participating in each health plan in the market. This method, which Justice Department officials have referred to in speeches, adjusts for the overcounting of market share that otherwise results when—as is often the case—physicians participate in multiple plans. *See* "Antitrust Enforcement Policy and the Treatment of Horizontal Price Restraints: Lessons for the Health Care Industry," Address by James F. Rill, Assistant Attorney General, Antitrust Division, Dept. of Justice, at 10 n.3 (Feb. 15, 1991).

[42] M. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Prob. 237, 242–43 (1988).

purchaser that procures medical services on behalf of all citizens.[43] Even so-called "managed competition" approaches foster the creation of large purchasing cooperatives and the operation of "relatively few managed care organizations in each geographic area."[44] Although these proposals differ greatly in their particulars, they share the underlying goal of encouraging payers—as the *Alston* court put it in a somewhat different context—to "use the clout of their consumer base to drive down health care service fees."[45]

As a matter of economics, the exercise of monopsony power by large payers or coalitions of payers should cause as much concern as anticompetitive conduct on the part of providers. "[I]t is bedrock economic theory that powerful buyers, whether acting individually, as a monopsonist, or in collusion with other buyers are capable of causing the same economic harm that the antitrust laws are designed to prevent."[46] In the health care context, the exercise of monopsony power by large payers can be expected to result in deteriorations of quality and access, including "long waits, a slow rate of technical progress, and contrived shortages of useful care."[47]

To date, however, antitrust officials have taken a benign view of the monopsony power exercised by large third party payers. Indeed, they have sometimes suggested that buyer-side purchasing power in health care may be desirable because it drives prices down. This position represents "nothing less than a frontal assault on the basic policy of the Sherman Act."[48] The antitrust laws embody the principle that competition alone must be relied upon to determine what is an appropriate price.

Current antitrust enforcement policy is therefore both discriminatory to physicians and inconsistent on its own terms. More importantly, however, this policy stands as an obstacle to the development of a rational and just system of health care.

B.

In markets in which a payer or coalition of payers acquires a dominant market share, the exercise of some countervailing strength by physicians is not anticompetitive and should not subject the physicians to antitrust prosecution. The AMA is therefore proposing that physicians faced with dominant payers (*e.g.*, 35 percent or greater market share) should be permitted to form negotiating groups of reasonable size (*e.g.*, 20 percent of the physicians in the community or in any specialty) to bargain collectively with the dominant payer. A payer should be treated as a dominant payer if it covers at least 35 percent of the individuals who are covered by private health insurance in any relevant geographic market.[49]

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[43] *See, e.g.*, D. Himmelstein & S. Woolhandler, *A National Health Program for the United Stotes: A Physicians' Proposal*, 320 New Eng. J. Med. 102 (1989).

[44] A. Enthoven & R. Kronick, *Universal Health Insurance Through Incentives Reform*, 265 J.A.M.A. 2532 (1991); A. Enthoven & R. Kronick, *A Consumer-Choice Health Plan for the 1990's: Universal Health Insurance in a System Designed to Promote Quality and Economy*, 320 New Eng. J. Med. 29 (1989). *See generally* J. Gaffney, S. Browning, & E. Hirshfeld, *Proposals to Reform the U.S. Health Care System: A Critical Review*, 1 Health Econ. 181 (1992).

[45] *United States* v. *Alston, supra*, 974 F.2d at 1214; *cf.* "The Role of Antitrust in Improving and Reforming the Health Care System," Address by Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission (October 15, 1992), at 4 ("The core concept of the system-wide reforms being proposed in the current debate on health care costs * * * is some form of managed care, relying in part on the purchasing power of prepaid health plans to negotiate aggressively for lower prices.").

[46] R. Blair & J. Harrison, *Cooperative Buying, Monopsony Power, and Antitrust Policy*, 86 Northwestern Univ. L. Rev. 331, 331 (1992); *see Vogel* v. *American Society of Appraisers*, 744 F.2d 598, 601 (7th Cir. 1954) (Posner, J.) ("[m]onopoly and monopsony are symmetrical distortions of competition from an economic standpoint."); *see also* H. Hovencamp, *Economics and Federal Antitrust Law*, sec. 1.2, at 17 (1985) ("monopsony can impose social costs on society similar to those caused by monopoly"); M. Pauly, *Monosony Power in Health Insurance: Thinking Straight While Standing on Your Head*, 6 J. Health Econ. 73, 73 (1987) ("monopsony may have seriously adverse consequences for overall economic efficiency, whatever it does to price and expenditure levels").

[47] M. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237, 260 (1989). The monopsony problem has been addressed in a number of antitrust cases. The leading case is *Mandeville Island Farms* v. *American Crystal Sugar Co.*, 334 U.S. 219 (1948). *See also United States* v. *Griffith*, 334 U.S. 100 (1949); *National Macaroni Mfg. Assoc.* v. *FTC*, 345 F.2d 421 (7th Cir. 1965); *United States* v. *Rice Growers Assoc*, 1986–2 Trade Cas. (CCH) para. 67,288 (E.D. Cal. 1986); *United States* v. *V.C. Itoh & Co.*, 1982–83 Trade Cas. (CCH) para. 65,010 (W.D. Wash. 1982).

[48] *See, e.g., National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 695 (1978).

[49] The 35 percent figure was cited by the Justice Department in a 1986 business review letter that considered the level at which a group purchasing cooperative might be able to exercise monopsony power. *See Gulf Wine & Spirit Shippers' Council, Inc.*, B.R.L. 86–7 (response letter).

The exercise of countervailing power by physicians in negotiations with dominant payers should not raise significant competitive concerns. A physician group that lacks market power cannot coerce a monopsonistic payer into raising its fees. If the two sides cannot reach agreement, the payer will simply obtain services from other physicians. And, because of the payer's market strength, the physicians will face a strong incentive to offer attractive terms.

Indeed, allowing physicians to engage in collective conduct is both necessary and appropriate. First, far from undermining competition, such collective conduct should improve the competitive functioning of the system. By providing a "check" on the payer's monopsony power, such conduct will help to counteract the "distortions of competition" that monopsony may otherwise produce.[50] In the health care context, such distortions would include deteriorations in the quality of and access to care.[51]

Physicians acting collectively can combat such distortions by acting as representatives of their patients' interests. In this regard, it is far too simplistic to suppose that payers act as "consumers' surrogates."[52] The interests of payers and patients diverge in significant respects. Payers aim to control utilization and cost. Patients care about costs too, but they also have an intense interest in obtaining medical services of high quality and in maintaining a choice of physicians. Through collective action, physicians can help minimize the harmful effects of monopsony on patients' interests.

Second, by permitting physicians to join together in negotiating groups of reasonable size, significant transactional efficiencies could also be achieved. Large payers could obtain a panel of physicians by negotiating with a few groups, rather than with hundreds of individual physicians. Physician groups would compete vigorously to obtain the large payer's contract. They might also be encouraged to integrate their practices by forming IPA's or other procompetitive joint ventures.

Finally, physicians confronted with large aggregations of purchasing power should—in the words of the *Alston* court—be "entitled to take some joint action" in order to "level the bargaining imbalance."[53] It is simply inequitable to encourage concentration on the purchasing side of medical services transactions, while prohibiting collective bargaining on the providers' side. As one commentator has stated, "good-faith collective bargaining" ought to be "the monopsonist's duty."[54]

In this regard, physicians today face a situation comparable to those historical circumstances in which antitrust reforms have been enacted. Consider, for example, the following passage from the legislative history of the Capper-Volstead Act,[55] a statute that created a partial antitrust exemption for agricultural cooperatives:

> The farmers are not asking a chance to oppress the public, but insist that they should be given a fair opportunity to meet business conditions as they exist—a condition that is very unfair under the present law. Whenever a farmer seeks to sell his products he meets in the market place the representatives of vast aggregations of organized capital that largely determine the price of his products. Personally he has very little if anything to say about the price. If he seeks to associate himself with his neighbors for the purpose of collectively negotiating for a fair price, he is threatened with prosecution.[56]

Like the farmers in the early part of this century, physicians today compete as individuals or small groups in a highly atomized seller's market. Their services are paid for by "vast aggregations of organized capital"—powerful third party payers who are likely to grow still larger in the context of health care reform. Under current antitrust policy, however, physicians who attempt to join together to bargain collectively with a powerful payer are "threatened with prosecution."

This state of affairs is bad for physicians, bad for patients, and bad for the efficient delivery of health care in America. Fairness dictates that physicians dealing with market dominant payers should be permitted to assert some countervailing strength. The legislation attached as Appendix A would achieve this result.

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[50] *Vogel, supra,* 744 F.2d at 601.

[51] M. Pauly, *supra* n. 42, at 260.

[52] K. Arquit, *supra* n. 44, at 5.

[53] 974 F.2d at 1214.

[54] R. Pfizenmayer, *Antitrust Law and Collective Physician Negotiations with Third Parties: The Relative Value Guide Object Lesson,* 7 J. Health Politics, Policy & L. 128, 151 (1982).

[55] 15 U.S.C. sec. 17.

[56] H.R. Rep. No. 24, 67th Cong., 1st Sess. 2 (1921) (quoted in 1 P. Areeda & D. Turner, *Antitrust Law* para. 228, at 186 n.34 (1978)).

IV. THE ANTITRUST LAWS SHOULD NOT PROHIBIT PHYSICIANS AFFILIATED WITH A MANAGED CARE PLAN FROM COLLECTIVELY PROVIDING THEIR INPUT ON MEDICAL REVIEW CRITERIA, QUALITY ASSURANCE PROGRAMS, AND OTHER FINANCIAL AND ADMINISTRATIVE DECISIONS OF THE PLAN

As noted above, managed care plans are taking aggressive action to control costs. Current legislative proposals envision a system of managed competition in which the power of these plans would be even greater.[57] While cost control is a desirable objective, excessive cost cutting can result in a refusal to pay for medically necessary services or in an unreasonable reduction in the quality of care received by plan enrollees. Either result is, of course, directly contrary to the interests of patients.

The AMA believes that the most effective way of sensitizing managed care plans to the impact on patients of their decisions regarding coverage, medical policies, and reimbursement is to give physicians a voice in those decisions. Physicians are representatives of the interests of patients in quality of and access to care. As such, they provide a unique perspective that can assist managed care plans in formulating and implementing policies. While all decisions must ultimately be made by the plans themselves, physicians affiliated with the plans should be encouraged to provide their collective input on such decisions.

To this end, the AMA is proposing the Managed Care Improvement Act of 1993 (copy attached as Appendix B). The Act would require managed care plans to establish committees of physicians that would advise management on medical review criteria, quality assurance programs, grievance mechanisms, and certain financial and administrative matters. It would also authorize physicians affiliated with a plan to provide their collective input on these and other matters—as long as no boycott was threatened or engaged in.

If physicians are to be encouraged to serve on committees advising managed care plans and otherwise to provide their collective views to such plans, they must be assured of immunity from the antitrust laws where they have acted in good faith. Such immunity is necessitated by cases in which well meaning physicians have become embroiled in protracted antitrust litigation for attempting to formulate thoughtful medical policies.[58] It is also necessitated by physician reluctance to engage in any sort of collective conduct as a result of a number of well publicized cases in which physicians have been held liable for such action.[59] Accordingly, the Act includes a provision immunizing from the antitrust laws collective input to managed care plans by physicians affiliated with these plans if the physicians act in good faith and do not threaten a boycott.

The AMA submits that antitrust immunity for physicians in these circumstances is sound policy. Collective presentation of physicians' views to payers, including views on reimbursement matters, does not violate the antitrust laws as long as the presentations are not accompanied by a threat of boycott.[60] Statutory immunity would simply enable physicians to avoid the debilitating costs of plenary antitrust litigation and would thus encourage them to participate in decision-making by managed care plans. Accordingly, the AMA respectfully requests that federal antitrust agencies support the immunity provisions of the Managed Care Improvement Act of 1993.

CONCLUSION

America's health care delivery system stands on the threshold of major change. The AMA supports reforms that will improve the cost-effectiveness of care and that will provide access to care for the uninsured. If these reforms are to work, however, they must be accompanied by modifications in the antitrust laws—or at least in current enforcement policies—to permit a meaningful physician role in negotiations with payers. Such modifications are essential if the antitrust laws are truly to serve as a *patient* welfare prescription.

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[57] *See* p. 27, nn. 43–44, *supra*.

[58] *See, e.g. Schachar* v. *American Academy of Ophthalmology* 870 F.2d 397 (7th Cir. 1989); *Marresse* v. *American Academy of Orthopaedic Surgeons*, 977 F.2d 585 (7th Cir. 1992) (text in WESTLAW); *Koefoot* v. *American College of Surgeons*, 1987-1 Trade Cases para. 67,508 (N.D. Ill. 1986).

[59] *See, e.g., Alston, supra*, 974 F.2d 1206; *Patrick* v. *Burget*, 486 U.S. 94 (1988); *Weiss* v. *York Hospital*, 745 F.2d 986 (3d Cir. 1984).

[60] *Michigan State Medical Society*, 101 F.T.C. 191 (1983).

APPENDIX A

PHYSICIAN-HEALTH PLAN NEGOTIATIONS ACT

Section 1. *Short Title.* This Act may be cited as the "Physician-Health Plan Negotiations Act of 1993."

Section 2. *Policy and Intent.* It shall be the policy of the United States to encourage the formation of cooperative physician networks for the purpose of contracting for and delivering efficient and high quality medical services. The intent of this Act is to facilitate negotiations by physician networks with health plans such as indemnity health insurance plans, health maintenance organizations, preferred provider organizations, managed care plans, self-insured employee benefit plans, and other third party payment programs. It is the further intent of this Act to encourage input by networks of physicians into the administration, coverage and payment policies of such health plans. This Act shall not be construed as restricting or prohibiting any physician arrangements or activities that are otherwise permissible under the federal antitrust laws or the law of any State.

Section 3. *Collective Development and Presentation of Position Statements.*

(a) Networks of independently practicing physicians that satisfy the criteria set forth in subsection (b) shall be permitted collectively to develop and present position statements to health plans, notwithstanding anything in the antitrust laws or the law of any State to the contrary. Such position statements may include:

(1) Cost data in support of a request to modify a health plan's fee schedule;

(2) Suggestions as to specific proposed reimbursement levels; and

(3) Proposals regarding payment procedures, utilization review, administrative requirements, coverage issues and other aspects of the operations of the health plan.

The physicians may select an agent (such as a consultant, attorney, medical society, or other such person or entity) for purposes of developing and presenting such position statements.

(b) To qualify for the legal protection set forth in subsection (a), physician networks that collectively develop or present position statements shall—

(1) Permit any individual physician in the network to negotiate and enter into individual arrangements with any health plan (including the plan to which a position statement is submitted);

(2) Permit any individual physician in the network to enter into arrangements with other physician networks for purposes of negotiating arrangements with any health plan;

(3) Not exchange information among independently practicing physicians in the network concerning their usual charges, except on an aggregate or composite basis that does not reveal the charges of any individual physician; and

(4) Not boycott or threaten a boycott of health plans that do not accept the proposals made by the physicians.

Section 4. *Negotiations with Dominant Health Plans.*

(a) Physicians shall be permitted to form one or more Dominant Health Plan Negotiating Networks for purposes of negotiating and entering into contracts with a health plan that has market dominance. A health plan shall be found to have market dominance if the plan covers at least thirty five percent (35 percent) of the individuals who are covered by private health insurance in any relevant geographic market.

(b) Dominant Health Plan Negotiating Networks will be subject to the following restrictions:

(1) The network shall include no more than twenty percent (20 percent) of the physicians and no more than twenty percent (20 percent) of the specialists in the relevant geographic market. Notwithstanding the foregoing limitation, the network may include at least two specialists or groups in each specialty in a relevant geographic market, provided that the network includes physicians from at least three specialties.

(2) The network shall limit its activities to negotiations with dominant health plans.

(3) Physicians participating in the network shall not exchange information concerning their usual charges or any other charges unrelated to the dominant health plan with which the network is negotiating, except on an aggregate or composite basis that does not reveal the charges of any individual physician; and

(4) Physicians participating in the network shall be free to adopt whatever arrangements they may desire with non-dominant health plans.

Section 5. *Qualified Independent Practice Networks.*

(a) Physicians may form Qualified Independent Practice Networks ("QIPN's") in accordance with the requirements set forth herein. Any QIPN which satisfies the conditions set forth herein, together with all of its members, shall be conclusively deemed to be a single entity for antitrust purposes. Neither the formation of, nor the activities of, a qualifying QIPN and its members shall be found to be a contract, combination or conspiracy in restraint of trade under Section 1 of the Sherman Act or an unfair method of competition under section 5 of the Federal Trade commission Act.

(b) In order to qualify as a QIPN, a physician network must satisfy the following:

(1) The total number of physicians participating in the network shall not exceed twenty percent (20 percent) of the physicians in the relevant geographic market;

(2) The total number of physicians from a particular specialty participating in the network shall not exceed twenty percent (20 percent) of the specialists in the relevant geographic market, except that the network may include at least two specialists or groups in each specialty;

(3) The network shall either include or have entered into arrangements with physicians from at least three specialties;

(4) Any network that is not a party to a service contract with at least one health plan for a period of at least one hundred eighty consecutive days shall be terminated;

(5) The network shall not enter into any arrangement with any health plan that limits the ability of the network to contract with any competing health plans unless the network represents fewer than ten percent (10 percent) of the physicians and fewer than ten percent (10 percent) of the members of each specialty in the relevant geographic market;

(6) The network must file an application with the Secretary showing the organizational structure of the network, the initial members of the network, and compliance with each of the requirements of this section.

(c) In order to be qualified under this section, a physician network must satisfy at least three of the following criteria:

(1) The network will adopt practice parameters that will be followed by its members in providing services;

(2) The network will adopt and follow a quality assurance ("QA") program that regularly reviews all of the services provided by members of the network;

(3) Each of the members of the network will contribute a pro rata portion of the total equity capitalization of the QIPN;

(4) The network will be responsible for billing and collecting fees for the services of the members of the network;

(5) The members of the network, through capitation payments, risk sharing withholds, or other such mechanisms, will share the risk of overutilization of services;

(6) The network will employ practice profiling, outcomes research or similar techniques to evaluate, critique and improve the performance of each of the members of the network.

(d) For purposes of subsections (b) and (c), in determining the percentage of physicians in a relevant geographic market who participate in a physician network, the

numerator shall consist of the number of physicians who participate in the network and the denominator shall consist of the sum of the total numbers of physicians participating in each health plan in the relevant geographic market (so that in a market in which all the physicians participate in four health plans, each plan would represent 25 percent of the physicians in the market). In determining the percentage of physicians of a particular specialty in a relevant geographic market who participate in a physician network, the numerator shall consist of the number of physicians in that specialty who participate in the network and the denominator shall consist of the sum of the total numbers of physicians in that specialty participating in each health plan in the relevant geographic market.

(e) By January 1, 1994, the Secretary shall establish application forms for QIPN's which will enable applicants to demonstrate compliance with each of the requirements set forth herein. Such applications shall be filed with the Secretary at least thirty days prior to commencing operations and every five years thereafter. The Secretary shall have thirty days following its receipt of an application to determine whether the applicant complies with each of the requirements of this section. If the Secretary determines that an applicant does not meet the qualifications of this section, the Secretary shall inform the applicant in writing within thirty days of the date of the application of the specific reasons why the applicant does not comply with this section. If the Secretary does not inform the applicant of its rejection of the application within thirty days, the applicant shall be conclusively deemed to qualify as a QIPN under this section.

Section 6. *Other Physician Networks.* The Secretary shall, by January 1, 1994, promulgate regulations establishing a process whereby physician networks other than QIPN's may apply to the Secretary for a finding that the network's formation and operations shall be conclusively deemed lawful under the antitrust laws. The regulations shall specify criteria that the Secretary shall consider prior to taking action on such applications. Such regulations shall be promulgated in accordance with the federal Negotiated Rulemaking Act of 1990, 5 U.S.C. section 581 *et seq.* The Secretary shall include representatives of national physician organizations in the negotiated rulemaking proceedings.

Section 7. *Definitions.* Specific terms in this Act shall be defined as follows:

(a) *Health Plan.* "Health plan" shall mean any indemnity health insurance plan, health maintenance organization, preferred provider organization, managed care plan, self-insured employee benefit plan, or other third party payment program that provides reimbursement on behalf of persons covered by the plan for the expense of obtaining health care services or that directly provides health care services in return for premiums paid on behalf of covered individuals.

(b) *Specialty.* "Specialty" shall mean one of the following areas of medical practice: Allergy and Immunology, Anesthesiology, Colon and Rectal Surgery, Dermatology, Emergency Medicine, Family Practice, Internal Medicine, Neurological Surgery, Neurology, Nuclear Medicine, Obstetrics-Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Preventive Medicine, Psychiatry, Radiology, Surgery, Thoracic Surgery, and Urology.

(c) *Specialist.* "Specialist" shall mean any physician licensed by a State to practice medicine who is Board-certified or Board-eligible in one or more specialties.

(d) *Secretary.* "Secretary" shall mean the Secretary of the United States Department of Health and Human Services.

Section 8. *Regulations.* The Secretary may promulgate regulations to implement the requirements of this Act. All such regulations shall be promulgated in accordance with the federal Negotiated Rulemaking Act of 1990, 5 U.S.C. section 581 *et seq.* The Secretary shall include representatives of national physician organizations in the negotiated rulemaking proceedings.

Section 9. *Preemption.* The provisions of this Act shall supersede any and all federal and state laws, including antitrust and trade regulation laws, that might restrict, impose liability for, or otherwise limit physicians, physician networks, Dominant Health Plan Negotiating Networks, or QIPN's from operating in accordance with this Act and any regulations promulgated hereunder.

Appendix B

Managed Care Improvement Act of 1993

Section 1. *Short Title.*

This Act may be cited as the "Managed Care Improvement Act of 1993."

Section 2. *Policy.*

It shall be the policy of the United States to:

(A) require Managed Care Plans to establish committees through which physicians who contract with such Plans may provide advice and recommendations with respect to the Plans' medical review criteria, quality assurance programs, grievance mechanisms, and certain financial and administrative matters;

(B) protect from retaliation physicians who in good faith provide such advice and recommendations to Plans; and

(C) immunize from antitrust liability physicians who participate in good faith in various collective activities related to the purposes of this Act.

Section 3. *Definitions.*

(A) *Affiliated With.* The term "affiliated with" means under agreement, either by written contract or otherwise, to provide services to participants in a Managed Care Plan.

(B) *Managed Care.* The term "managed care" means the systems or techniques generally used by public or private third-party payers or their agents to affect access to and control payment for health care services.

(C) *Managed Care Plan.* The term "Managed Care Plan" or "Plan" means any public or private organization that utilizes managed care systems or techniques. This term includes, but is not limited to, health maintenance organizations and preferred provider organizations. It does not include hospitals.

(D) *Participant.* The term "participant" means any individual for whom a Plan is responsible for providing health care or health care coverage.

Section 4. *Committees.*

(A) *Establishment of Committees.*

Every Managed Care Plan affecting interstate commerce shall establish, in addition to any other committee that the Plan may establish, (1) a Medical Review Committee, (2) a Quality Assurance Committee, (3) a Grievance Committee, and (4) a Financial and Administrative Matters Committee.

(B) *Purpose and Function of Committees.*

Each Committee established under subsection (A) of this Section shall be consulted by, and shall advise, the Managed Care Plan on the issues for which it has responsibility under subsection (C) of this Section. The Plan shall take into account any advice or recommendations provided by such Committee. If the Plan rejects or substantially modifies any advice or recommendation provided by a Committee, a representative of the Plan shall meet with the Chair of the Committee or other representative designated by the Committee and shall provide a specific explanation as to why the Plan rejected the advice or recommendation of the Committee.

(C) *Responsibilities of Committees.*

(i) The Medical Review Committee shall be responsible for periodically reviewing and making recommendations to the Plan regarding the services that the Plan provides or covers, any restrictions that the Plan imposes on the availability or utilization of such services, the eligibility of a Plan participant for a specific service if a question arises about such eligibility, and any restrictions that the Plan places on the practice of medicine in connection with the performance of services provided to Plan participants.

(ii) The Quality Assurance Committee shall be responsible for reviewing and making recommendations to the Plan with respect to the quality of care provided to Plan participants and with respect to utilization of medical services by such participants.

(iii) The Grievance Committee shall be responsible for advising and making recommendations to the Plan (a) on procedures for effectively and fairly considering

any complaint made by or on behalf of any Plan participant about the quality of care provided by any physician and (b) on the appropriate action to be taken by the Plan with respect to any physician about whom a complaint has been made.

(iv) The Financial and Administrative Matters Committee shall be responsible for advising and making recommendations to the Plan on reimbursement issues (including fee schedules), the structure of any financial incentive program operated by the Plan, and on any other financial or administrative matter of general concern to the physicians affiliated with the Plan—including, but not limited to, payment procedures, the documentation that physicians must provide to the Plan to qualify for payment, mechanisms for referring patients within the Plan, and methods for verifying coverage of patients by the Plan.

(D) *Composition of Committees.*

Each Committee established in accordance with this Section shall be comprised of no less than three (3) and no more than five (5) physicians affiliated with the Plan. These physicians shall be selected by the Plan making reasonable efforts to assure that such physicians represent a variety of medical specialties and, where appropriate, of different physicians and medical practices affiliated with the Plan. Each Committee shall designate its own Chair.

Section 5. *Collective Development of Positions.*

Physicians affiliated with a Plan may collectively develop position statements on issues relating to their relationships with the Plan and relationships between the Plan and participants. They may present these statements to the Managed Care Plan either through a Committee established by this Chapter or directly. They may utilize consultants, attorneys, medical societies, or other persons or entities for the purposes of developing and presenting position statements.

Section 6. *Restrictions on Physicians Advising Plans.*

Notwithstanding the foregoing, no independently practicing physicians who serve on any Committee or who otherwise provide advice, recommendations, or position statements to a Plan shall:

(A) Discuss with any other physicians affiliated with the Plan their usual charges or any other pricing to patients outside the plan;

(B) Collectively boycott or threaten to boycott the Plan if the Plan does not accept a recommendation made by those physicians.

Section 7. *Protection Against Retaliation.*

No physician who serves in good faith on a Committee as described in Section 4 of this Chapter or who participates in good faith in the collective development of a position statement as described in Section 5 of this Chapter, may be terminated by the Plan because of such service or participation.

Section 8. *Antitrust Immunity.*

No physician who serves in good faith on a Committee as described in Section 4 of this Chapter or who participates in good faith in the collective development of a position statement as described in Section 5 of this Chapter, may be subject to civil or criminal liability under any federal or state antitrust law, except to the extent that the physician engages in any activity prohibited by Section 6 of this Chapter.

Section 9. *Preemption.*

All State and local laws, regulations, ordinances, or other rules that are inconsistent with the provisions of this Chapter are hereby preempted.

Section 10. *Regulations.*

The Department of Health and Human Services shall have authority to promulgate regulations to implement the provisions of this Chapter in accordance with the provisions of the Negotiated Rulemaking Act, 5 U.S.C. sections 581 *et seq.*

ATTACHMENT C

American Medical Association
Physicians dedicated to the health of America

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April 30, 1992

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Howe & Hutton, Ltd.
20 North Wacker Drive
Chicago, Illinois 60606
Counsel for Chicago Medical Society

Donald S. Clark
Secretary
Federal Trade Commission
6th & Pennsylvania Avenue
Washington, D.C. 20530

Dear Mr. Clark:

Pursuant to 16 C.F.R. 1.1, the American Medical Association (AMA) and the Chicago Medical Society (CMS) hereby request an advisory opinion that would permit the AMA, its constituent medical societies, and its component medical societies to engage in professional peer review of physician fees pursuant to procedures developed by the AMA.[1]

Under the AMA's contemplated program, state or county societies would perform most of the professional peer review of fees.[2] State societies would also act as appellate bodies for opinions or decisions of the county medical societies, and under some circumstances would act as the initial forum for peer review of fees. The AMA would participate as the appellate body for opinions and decisions of the state societies, and under rare circumstances would initiate its own peer review proceedings.

The Federal Trade Commission (FTC) has issued advisory opinions about the operation of professional peer review of fees.[3] The FTC has recognized that, properly managed, professional fee peer review can yield important procompetitive benefits.[4] In particular, fee peer review can increase the

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1 *Pursuant to the AMA's Constitution, constituent medical societies are "medical associations of states, commonwealths, territories or insular possessions which are, or which may hereafter be, federated to form the American Medical Association." Component societies "are those county or district medical societies contained within the territory of and chartered by the respective state associations."*

2 *The AMA believes that many of these medical societies will adopt the proposed fee peer review procedures if they are found to be compatible with the antitrust laws by the Federal Trade Commission. See the letters of support from state and county societies submitted with this request. Indeed, CMS, which is the largest county medical society in the nation, has chosen to join the AMA in this request because it desires to conduct the review of complaints about physician fees in the manner requested for the procompetitive reasons that are discussed infra.*

3 *See, e.g., Medical Society of Passaic County (January 3, 1986); American Podiatry Association (March 13, 1984), and Iowa Dental Association, 99 F.T.C. 648 (1982).*

4 *Ibid., and see "Peer Review and the Antitrust Laws," Remarks of Mark J. Horoschak, Assistant Director for Health Care, Bureau of Competition, Federal Trade*

flow of information about physician fees to patients, enabling them to compare fees when selecting a physician.

However, the FTC has also expressed concern that improperly managed fee peer review could result in price-fixing agreements and the[5] advisory opinions and guidelines issued by the FTC have been so restrictive that few medical societies engage in fee review today. We believe they are unnecessarily restrictive and are thereby depriving patients of an important public service.[6] In particular, we object to the FTC guidelines which advise that:

1. Opinions of the peer reviewers must be advisory only and not coercive—that physicians must not be required either to participate in the review process or to comply with the opinion of the reviewers; and

2. That physicians must not be subject to discipline for charging any particular fee or for refusing to adhere to the opinion of reviewers.

A complete summary of the AMA's proposed procedures for professional fee peer review is included in subsequent portions of this letter. In brief, the procedures would generally adhere to the FTC guidelines, but we make the two important changes described above. The process would involve mediation of complaints about fees, but physician participation would be mandatory under the AMA procedures and physicians can be disciplined for fee gouging.[7] While the emphasis of the AMA's proposed program is on mediation, the AMA and the CMS believe that medical societies should be able to discipline members who engage in egregious conduct.

The AMA and CMS believe that these differences would enhance the procompetitive benefits of professional fee peer review by medical societies. Almost all fee peer review carried on by component societies is in response to patient complaints. Mandatory participation would increase the flow of information to patients about fees, and it would increase patient confidence in the market for physician services. The ability to discipline fee gougers would also increase patient confidence in the market.

When a medical society cannot require a member to participate in fee peer review in response to a complaint, the patient is always unhappy, sometimes harmed and the profession is denied the ability to enforce its code of ethics in a critical respect.

The AMA has had intermittent discussions with prior Chairmen of the FTC for the relief sought here for over seven years. We have sensed greater flexibility and a broader perspective from this Commission on certain matters and we submitted a draft of this request for an advisory opinion to the staff of the Bureau of Competition for an informal reaction. Staff has responded by requesting a substantial amount of information in addition to the material set forth in this request. Some of the questions asked by staff are clarifications that have been addressed by modifying this letter. Other information requested can only be obtained by calling upon the experiences of the constituent and component societies. The AMA and the CMS are in the process of gathering that information and will submit it shortly, but we do not believe it is necessary given the nature of the modifications we are

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Commission, before the AMA National Leadership Conference, February 25, 1990, and for the perspective of the Antitrust Division of the U.S. Department of Justice see "Business Self Regulation, An Enforcement Policy of Cautious Tolerance," Remarks of Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, Before the Chicago Bar Association, January 27, 1989

5 *See fn. 3, supra.*

6 *Horoschak, fn. 4, supra.*

7 *Fee gouging has been long been considered unethical by the profession. See Opinion 6.05, "Fees for Medical Services", in the Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1992)*

seeking. For the reasons stated here and in the cover letter to Chairman Steiger, it is past time to grant the relief we seek.

The Procedures Proposed By The AMA For Professional Peer Review Of Physician Fees

a. Intent of the AMA's Proposed Procedures

This request for an advisory opinion is being submitted as part of a broad, procompetitive effort to enhance professional self regulation by physicians. The goal is to respond to widespread disenchantment with the health care system by addressing the complaints of patients, payers, and others about individual physicians in light of the ethical code of the profession. It is essential that physicians address this lack of confidence if the market for physician services is to function effectively. The object of enhanced self regulation is to restore confidence by providing a means to resolve patient and payer complaints about individual physicians and by promoting adherence to high standards of conduct by physicians.

This effort to enhance professional self regulation is procompetitive because it should result in greater protection of patient interests and provide a greater flow of information about physicians to patients, payers, and others. Patients will have greater confidence that their interests will be observed and that they will not be exploited when being cared for by a physician. In addition, there will be more information available for patients to compare the characteristics of physicians when choosing a provider. Further, individual physicians will obtain more information about the patient perspective and are likely to respond by changing their practice procedures to improve the experience of the patient.

The AMA hopes to achieve enhanced self regulation by reviving a professional peer review structure that was once active, but which has become increasingly inactive in certain matters in recent years. The AMA and its constituent and component societies have in place the organizational structure necessary to handle complaints about fees and other matters from patients, payers, and others. In fact, most of these medical societies have bylaws that provide for standing committees designed to mediate and resolve patient grievances and to discipline members that engage in unethical conduct. Some of these societies hear patient complaints about fees. However, these committees have become inactive or underused in many, if not most, geographic areas. There are some county and state societies with active grievance committees, but most do not review complaints about fees. The disciplinary function has virtually stopped in most areas.

The AMA has proposed the fee peer review procedures at issue in this request for two reasons. First, The AMA and the constituent and component medical societies view fee peer review as an important activity. Second, because of its importance, an FTC approved set of procedures that enhances the ability of these committees to mediate complaints about fees and to discipline fee gougers would provide an excellent means to promote the use of the peer review system. As is discussed in the next section of this letter, one of the reasons why the peer review structure has become increasingly inactive is fear of litigation, especially antitrust litigation. An advisory opinion from the FTC which found that the proposed guidelines for fee peer review are compatible with the antitrust laws would provide assurances to medical societies that peer review can take place without excessive liability risks.

Medical societies consider professional fee peer review to be important because most medical societies regularly receive complaints from patients and other persons alleging that a physician charged an unreasonably high fee. The complaints are made with the expectation that the medical society will be able to provide relief. In addition, on some occasions legislators and others have criticized medical societies for not doing more about physicians who overcharge. On a broader level, much concern has been expressed about rising health care costs and society's ability to pay for them. Medical societies want the ability to respond to these complaints and issues.

Another reason why fee peer review is considered to be important is that other issues often underlie and give rise to complaints about fees. Often these problems do not involve egregious or unethical conduct, but they are important for physicians to learn about and address. They include poor communications about the nature of the services provided by the physician, insensitive treatment by the physician or the physician's office staff, and patient dissatisfaction with the outcome of services. Physician fees often become the lightning rod for dissatisfaction with physician services. Mediation of fee disputes is an excellent way for these complaints to surface and be resolved. Medical societies believe that it is important for physicians to respond to these complaints in order to restore patient confidence in the market for physician services. It may be even more important to resolve these issues than to mediate fee disputes.

Another type of issue that often underlies complaints about fees is lack of agreement between physicians and patients about how services will be billed. For example, one type of complaint is colloquially known as "unbundling." That involves charging separate fees for services that a patient or payer believes should be combined into one service with one fee. Usually it is alleged that the fees charged for the unbundled services add up to a charge that is greater than the appropriate fee for the bundled services. The issue of service definition has become important in disputes about physician fees. Again, mediation is an ideal way to address this issue.

There are situations where egregious misconduct underlies a complaint about fees. For example, fee gouging is often accompanied by other unethical activity, such as fraud, taking advantage of a poorly informed patient, undue influence over a vulnerable patient, or the intentional provision of unnecessary services. There is a broad perception that physicians who engage in egregious misconduct are not punished, and are instead allowed to repeat their misdeeds. Medical societies believe that it is important that physicians who engage in egregious misconduct be held accountable if patient confidence in the medical profession is to be restored.

Finally, the AMA believes that enhancing professional fee peer review and physician self regulation in general will serve an important societal need. Patients want to have their complaints addressed, and the medical profession believes that it has the tradition and structure necessary to do the job effectively. Historically, the profession itself, as opposed to other institutions or regulators, has done the best job at taking the actions necessary to build public confidence in the market for physician services.[8]

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8 *Throughout its history, the profession has responded to the need to solve health care problems and to regulate itself in the public interest. During the mid and late 19th century, the profession organized medical societies and developed a code of ethics to distinguish physicians from the many competing health care practitioners that did not adhere to safe and scientific methods. Subsequently the profession initiated and helped operate the system of state licensure of allopathic physicians. At the turn of the century, the profession reformed the medical education industry and succeeded in eliminating the practice of granting diplomas for a fee and in closing substandard medical schools. A system of accrediting medical schools was developed that continues today, and which is operated by organized medicine. During the early part of the twentieth century, systems for accrediting graduate medical education programs and hospitals were developed by the profession, and the board certification of the American Board of Medical Specialties was organized. The net result has been the training of hundreds of thousands of physicians of high levels of competency and integrity, and their efforts to deliver high quality medicine has been an extraordinary success story. The impetus and basic organizational structure for the system has come from the profession itself, in particular, the American Medical Association. See generally, Morris Fishbein, M.D., A History of the American Medical Association, 1847-1947, W.D. Saunders Company, Philadelphia, Pa. (1947); Frank D. Campion, The AMA and U.S. Health Policy Since 1940, American Medical Association, Chicago, Illinois (1984); and Paul Starr, The Social Transformation of American Medicine, Basic Books, New York (1982).*

b. The Existing Committee Structure

1. Patient Grievance Committees and Physician Disciplinary Committees

As of 1987, almost all of the county medical societies had "patient grievance committees" (PGCs) and physician disciplinary committees (PDCs).[9] The purpose of a PGC is to take complaints from patients about physicians and to resolve them, primarily through mediation. If a complaint involves a serious charge of misconduct, the PGC may refer it to a PDC or to a state or federal regulatory agency. PDCs hear serious charges of ethical violations by a physician that might result in an action that affects the physician's membership.

State medical societies also operate PGCs and PDCs. However, county medical societies are intended to handle initial complaints, with state medical societies acting as an appellate body for parties dissatisfied with the opinions or decisions of the county societies. State PGCs and PDCs will handle initial complaints for counties in rural areas that do not have sufficient members or staff to operate committees. In addition, state PGCs and PDCs usually have discretion to handle initial complaints from any area in appropriate situations.

The AMA does not have a PGC or a PDC. However, the Council on Ethical and Judicial Affairs of the AMA (CEJA) acts as an appellate body for parties dissatisfied with opinions or decisions of state PGCs and PDCs. CEJA also is authorized to conduct its own investigation and hearings into charges of unethical conduct in appropriate situations.

The most active PGCs are operated by county societies that cover large metropolitan areas. These counties have a substantial membership, sometimes larger than rural states, and have the resources to operate active PGCs. The AMA believes that many counties do not have active PGCs, and states are not very active in this area either.

Counties and states have not been active in operating PDCs. The AMA does not have precise information about the operations of PDCs, but it appears that PDC activity has almost halted except in a few large states or counties.

There are several likely reasons for the low level of activity in PDCs. One is fear of litigation. As of 1987, ten state societies and 13 county societies reported that they had been investigated by the FTC, the United States Department of Justice (DOJ), or another government agency during the previous five years. Ten state societies and 20 county societies were sued by a member or a nonmember physician during the same period.[10] Many of the investigations and lawsuits concerned antitrust issues associated with membership. Defense of a lawsuit is a major expense to a state or county society. Many have decided to minimize their exposure to lawsuits by reducing PGC activity and PDC activity.

In addition to fear of litigation, other factors that may cause a low level of activity are a shortage of resources, and a natural disinclination to engage in disciplinary functions that might adversely affect a peer. These factors, combined with fear of becoming embroiled in expensive litigation, have been powerful disincentives.

Currently, the AMA is encouraging county and state medical societies to activate their PGCs and PDCs. As part of this effort, the AMA is preparing to handle more appeals from state PDCs and PGCs, and it is also providing guidance to state and county societies about how to operate the committees.

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9 *Directory of Activities, Volume II, 1987, State and County Medical Associations* American Medical Association, Chicago, Illinois (1987)

10 *Directory of Activities*, Fn 10, *supra*

2. Chicago Medical Society's Existing Committees

Pursuant to its bylaws, the CMS has standing Ethical Relations and Physicians Review Committees and Subcommittees on Fee Mediation and on Medical Practice. Under the CMS bylaws, failure to cooperate with these committees and subcommittees is grounds for discipline. However, as a matter of custom and practice, CMS has excepted fee peer review from mandatory participation. Members have not been required to cooperate with fee peer review and have not been disciplined if they refuse to participate.

The CMS Ethical Relations Committee is comparable to a PDC and is responsible for disciplinary actions against members, which could include censure, probation, suspension or expulsion.

The CMS Physicians Review Committee is comparable to a PGC. Its Subcommittee on Medical Practice is responsible for complaints concerning the quality and utilization of medical care and has as its goal to open up communications, through mediation, to reach a mutually satisfactory resolution. The Subcommittee's opinion is advisory and nonbinding. An opinion adverse to the physician may be appealed to the Physicians Review Committee and, in turn, to the Illinois State Medical Society.

The Subcommittee on Fee Mediation is responsible for complaints concerning physician fees and has as its goal to open up communications, through mediation, to encourage a mutually satisfactory resolution. The Subcommittee's opinion is advisory and nonbinding. If it is the opinion of the Subcommittee that the fee is above the range of usual and customary fees charged in the geographical area for similar medical services, the physician may appeal to the Physicians Review Committee. Decisions rendered by the Physicians Review Committee in a fee mediation case cannot be appealed.

The efforts of CMS' Subcommittee on Fee Mediation have been frustrated by the Subcommittee's inability to discipline physicians engaged in egregious conduct, such as repeated instances of fee gouging.

c. Guidelines for the Operation of PGC's & PDCs

As stated earlier, the AMA has developed guidelines for the operation of PDCs and PGCs. These guidelines include procedures for ensuring basic fairness to the parties involved, such as minimizing conflicts of interest among reviewing physicians and other "due process" style safeguards. In addition, the guidelines have other features designed to provide for the appropriate disposition of various types of complaints. Many of the guidelines are drawn from the historical practices of the PGCs and PDCs, and some of the guidelines are new. As a whole, the guidelines are a blend of existing practices and new recommendations.

These guidelines apply to all types of complaints handled by PDCs and PGCs, including the handling of complaints about fees. The guidelines also include a section about the handling of fee complaints in particular. The general guidelines are summarized below, and a summary of the guidelines for fee complaints follows immediately after.

1. General Guidelines

The AMA recommends that PGCs and PDCs screen complaints immediately after receipt to determine whether they should be handled by the committee, or referred to another committee or entity, or both. For example, state PGCs should generally refer complaints to the county PGC where the physician involved resides. PDCs should refer complaints that do not involve serious charges of misconduct to PGCs, and PGCs should refer complaints to a PDC when there is reasun to believe that serious misconduct is involved.

If there is reason to believe that a threat to the health of the physician's patients exists, then the state's licensing board and the physician's hospital should be notified immediately. When there is reason to believe that a violation of law has occurred, then the appropriate government law enforcement agencies should be notified. A PGC or PDC might hold parallel proceedings

when a state licensing board or licensing agency is notified, or it might wait for the outcome of any government actions, depending on the circumstances.

After screening of a complaint by a PGC, it should be investigated by one or more members of the PGC. An investigation should include interviews of the complaining party and the physician complained of[11], interviews of other physicians in the physician's field of practice, review of relevant documents, and other materials. Upon completion of the review, the reviewer should make a report to the full PGC, which should then make one of the following findings: (a) the physician did not act improperly, (b) the matter should be referred to the PDC and/or another entity for further proceedings, (c) the physician acted inappropriately but not enough to warrant disciplinary proceedings or proceedings by an outside agency, or (d) efforts should be made to resolve the matter through mediation. In situations where a physician has acted inappropriately, but not enough to warrant further proceedings, the PGC may require the physician to receive some education and agree to desist from the inappropriate conduct.

During mediation, the PGC should encourage the physician and the complainant to fully discuss their relative positions, with a view towards arriving at a settlement. Mediation should include education of both the complainant and the physician regarding the appropriate expectations and conduct of each. While settlements are voluntary, the medical society may also require the physician to pursue certain educational activities as a condition of the settlement. The educational activities are designed to prevent repetition of the conduct which led to the complaint.

PGC decisions may be appealed. Some societies allow internal appeals from the PGC decision, others do not. Once proceedings are final at the society which heard the complaint, the decision may be appealed to the next level of society. Counties appeal to states, and the state PGC decisions or appellate decisions can be appealed to the AMA. During appeals, complaints are not reinvestigated. The PGCs findings of fact are accepted if reasonable in view of the record.

PDCs should be independent of PGCs -- there should not be overlapping membership between the two committees in a society. The procedures followed by PDCs are also more formal. They are designed to qualify for the safe harbors provided by the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11111 et seq., which immunizes the participants in good faith peer review from civil liability if procedures designed to ensure fairness to the physician under review are followed. The procedures are also tailored in any given state to meet additional requirements imposed by state law for the conduct of peer review. Specific steps are spelled out for providing notice of the grounds for potential disciplinary action, notice of the disciplinary proceedings, the conduct of the hearings, providing notice of the decisions, and appeals.

A physician found by a PDC to have engaged in unethical conduct may be subject to a range of sanctions[12]. They include:

(a) Requiring the physician to undertake a specific program of remedial education.

(b) Requiring the physician to participate in a program of public service.

(c) Reprimand, censure, suspension of membership or expulsion from membership.

(d) Monitoring of the physician's practice for a specified period of time to ensure that corrective action has been taken.

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11 *At the present time, physician cooperation with investigations of fee complaints is voluntary.*

12 *At the present time, sanctions do not apply to fee gouging.*

(e) A fine to be paid to the medical society, or, if appropriate, restitution to the patient.

(f) Report to the state medical board with a recommendation that action or investigation be initiated.

(g) A combination of the sanctions listed in (a)-(e).

Factors in determining a sanction include not only the severity of the misconduct, but whether it was a first offense or part of a pattern of misconduct. More serious sanctions can also follow if, for example, a physician fails to participate in a program of remedial education or public service.

As is the case with PDCs, appeals may or may not be available within the society. Once the decision is final, it may be appealed to the next level, normally a state society, and then to the AMA.

Adverse actions taken by a PDC may be subject to federal and state reporting requirements. Under the federal Health Care Quality Improvement Act, any "professional review action" which adversely affects the membership of a physician must be reported to the state licensing board, which in turn reports to the National Practitioner Data Bank. Under the Act, "professional review actions" are those based on the competence or professional conduct of a physician, where the professional conduct affects or would adversely affect the health or welfare of a patient[13]. An action adversely affects membership by reducing, restricting, suspending, revoking, denying, or failing to renew membership.[14]

Many states require by law that determinations of unprofessional conduct related directly to patient care be reported to the licensing board. In addition, a PDC may make other disclosures. If there is a finding that substandard care has been provided, the peer review committee of the physician's hospital should be notified. Normally, reports of adverse actions by PDCs should be disclosed to the society's membership and the public through vehicles such as state medical society journals. However, in some cases it may make sense to impose a sanction privately, as where the offense is not egregious and the physician is a first time offender, or where there is a referral to an impaired physician program.

Ordinarily, PGCs and PDCs will have jurisdiction over medical society members only. Participation and cooperation with PGC and PDC activities is mandatory, and failure to cooperate is grounds for discipline. However, the AMA recommends that county and state societies encourage nonmembers to participate in PGC or PDC proceedings when complaints are received about them. In practice, some societies will accept a complaint about a nonmember only if the physician agrees to abide by the PGC or PDC procedures and decision. In the absence of an agreement, these societies will refer the complaint to the state licensing board or to another appropriate institution. Other societies will process a complaint against a nonmember without the nonmember's consent. The AMA believes that serious complaints about non-members who refuse to participate in a professional society's fee review process should be referred to the state licensing board.

Complaints may be filed by any person. Most commonly complaints are filed by patients, but they may also be filed by family or friends of patients, colleagues of the physician, or by third party payers.

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13 *It is uncertain whether fee-gouging would fall within the definition of a professional review action. Economic injuries such as being overcharged do not seem likely to affect the "health" of patients, but they might be considered to affect the "welfare" of patients.*

14 *A physician who is being considered for disciplinary action may seek to avoid the procedure by resigning. Under the Health Care Quality Improvement Act, resignations which take place during the pendency of a hospital peer review procedure must be reported. However, it is not clear whether resignations during the pendency of a medical society peer review process must be reported.*

d. How Fee Complaints Would Be Handled By PGCs and PDCs

Complaints about fees would be handled according to a specific set of procedures newly developed by the AMA. All fee complaints would first be referred to a county PGC covering the area where the physician resides, or the applicable state PGC if there is no county PGC. All complaints would be screened by the PGC to determine whether they should be referred to a state licensing board or a government enforcement agency. No complaints would be referred to a PDC without first being investigated by a PGC.

After investigation, a PGC would determine whether a fee complaint was a "level I" complaint or a "level II" complaint. A level I complaint would be a complaint that did not involve egregious conduct by the physician involved, and a level II complaint would be one which involves an allegation of egregious conduct that has a credible foundation. Egregious conduct would include situations where the fee charged arose from fraud, the exercise of undue influence over a vulnerable patient, taking advantage of the lack of knowledge of a patient, failing to inform a patient that an unusually high fee would be charged, intentionally providing unnecessary services, or other misconduct. It would also include charging a fee so high, for example two or three times the market level for a major procedure, as to constitute fee gouging[15]. Fees much higher than normal would not constitute fee gouging if **agreed to by a fully informed and competent patient or payer that was not subjected to undue influence. Complaints about fee gouging made by colleagues of the treating physician or by persons other than the patient would be reviewed to determine if the fees involved had been agreed to by a fully informed and competent patient. If there was such an agreement, the complaint would not be acted upon[16].**

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15 *FTC staff has asked for clarification about what constitutes fee gouging, and, in particular, what standards would be used to evaluate whether fee gouging occurred. The current reference point for what constitutes gouging is provided by Opinion [illegible] of the Code of Medical Ethics and Current Opinions of the Council on Ethical and* ***Judicial Affairs of the American Medical Association (1992), which is entitled "Fees for Medical Services". The Opinion states as follows:***

> ***A Physician should not charge or collect an illegal or excessive fee. For example, an illegal fee occurs when a physician accepts an assignment as full payment for services rendered to a Medicare patient and then bills the patient for an additional amount. A fee is excessive when after review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee. Factors to be considered as guides in determining the reasonableness of a fee include the following:***
>
> *A. the difficulty and/or uniqueness of the services performed and the time, skill and experience required;*
>
> *B. the fee customarily charged in the locality for similar physician services;*
>
> *C. the amount of the charges involved;*
>
> *D. the quality of performance,*
>
> *E. the nature and length of the professional relationship with the patient; and*
>
> *F. the experience, reputation and ability of the physician in performing the kind of services involved.*

16 *FTC staff has asked what the effect of a prior agreement between the physician and patient would be if the patient subsequently alleged a fee to involve fee gouging. If the patient was fully aware of what other physicians were charging for the services when the agreement was entered, and if the patient was not misled about some other factor which might lead a reasonable person to pay more than the market rate for a service, then the patient would be viewed as not having a valid complaint and the fee would not involve gouging. However, if the patient was not aware of the market rate,*

All level I complaints would be referred for mediation by the PGC. Level II complaints are those involving egregious conduct. The underlying patient or payer grievances in level II complaints would go through mediation for the purpose of resolving the complaints. However, level II complaints would also be referred to a PDC to evaluate whether the physician involved should be disciplined.

During mediation of complaints, each party would express views about the fee involved and any other conduct which gave rise to the complaint. The panel would express opinions about the reasonableness of the fee charged and the appropriateness of any other behavior at issue. Panel opinions would be based on their own expertise and experience in view of the circumstances of the complaint. The panel would consider the nature of the services performed, the difficulty of providing the services to the patient involved, any unusual problems or complexities that had to be managed, and other factors.

The opinions of the panel about the fee could be supplemented with other information about fees obtained from payer data bases, government fee schedules, academic studies, and the opinions of similarly situated physicians sought out by the panel. However, the medical society involved would not collect and maintain its own information about fees charged by physicians in its jurisdiction for use as a benchmark. Likewise, opinions of the panel about any other behavior of the physician involved could be supplemented by ethical codes and ethical opinions, articles about physician ethics, academic studies about the effects of certain conduct, and other materials. The object of the process would be to allow each side to gain an appreciation for the perspective of the other, and to be educated about the legitimate expectations of each party in the physician-patient relationship.

The goal of mediation would be to arrive at a settlement between the physician and the complaining party. No person, including the physician, would be required to agree to a settlement. However, participation in mediation by member physicians would be mandatory, and failure to cooperate with mediation would be grounds for discipline. Refusal to enter a settlement by a physician would not constitute lack of cooperation. Participation by the complaining party would be voluntary.

Settlements would not be limited to fee adjustments. The PGC could suggest, and the physician might agree to, other undertakings by the physician. These would be nonprice undertakings designed to educate physicians about how to prevent the type of incidents that give rise to patient complaints. These include how to manage the physician's office in ways that are considerate of the needs and interests of patients, how to communicate with patients, how to manage billing procedures so as to prevent errors, and other issues. For example, if repeated complaints about a physician are found to result from coding errors on claims forms, then education about coding may be appropriate.

If warranted, the PGC could require a physician to engage in a nonprice undertaking designed to prevent future complaints or misconduct. While these undertakings might arise out of mediation of the fee dispute, they would be directed towards nonprice issues that came to light during review of the complaint.

Proceedings during mediation would be kept confidential. No part of the proceedings would be open to the membership or the public. The report of the initial investigation would be kept confidential, and any record created or documents collected would also not be disclosed. Likewise, any settlement reached, including settlements that are conditioned on nonprice undertakings, would not be disclosed to the membership or to the public.

PDCs would review level II complaints to determine whether the physician should be disciplined. The procedures specified by HCQIA would be followed to ensure fairness to the physician charged with unethical conduct. Participation in the PDC proceeding would be mandatory for the physician involved.

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or was misled into believing that the presence of another factor warranted paying substantially more than the market rate, then the patient would be viewed as having a valid complaint

PDCs would keep their proceedings confidential. However, PDC decisions would be publicly disclosed. No information about the fee levels involved in a discipline for fee gouging would be disclosed, but the occurrence of the discipline would be made public. The purpose of disclosure would be to inform the public about the discipline.

The FTC Guidelines for Professional Peer Review of Fees

FTC staff have noted that, properly managed, professional peer review of physician fees results in three procompetitive benefits.[17] First, it is a means of providing information to patients about physician fees and other issues. That is procompetitive because the information allows the patient to decide whether a fee is excessive in relation to those charged by other physicians. It is an important benefit because there are often wide disparities in fee information between patients and health care providers.

Second, fee peer review can be an efficient and low cost method for resolving disputes about fees between physicians, patients, and payers. That is procompetitive because it facilitates the expedient and fair resolution of disputed transactions. At present, there is no effective forum available to resolve disputes. Courts are expensive and difficult to use, and they are often very slow. State licensing boards are not designed to resolve individual disputes. Instead, they investigate physicians in response to complaints. At present, most licensing boards have sufficient resources to investigate only the most serious complaints.[18]

Third and finally, fee peer review builds confidence in the market for physician services. Patients develop confidence because they believe that they will be treated fairly, and that they will receive objective information in the event of a dispute.

However, an improperly managed fee peer review program can be anticompetitive and violate the antitrust laws. FTC advisory opinions note that antitrust violations may occur if fee peer review becomes a device to coerce physicians to adhere to certain fee levels or to coerce payers into accepting fee levels, if it is used to discipline physicians who engage in legitimate competitive activities or innovative practices that are frowned upon by other practitioners, or if it becomes a vehicle for physicians to agree among themselves about fee levels.[19]

The advisory opinions note that antitrust violations can be avoided if all concerned parties view fee peer review solely as a means of mediating specific fee disputes, rather than a process for the collective sanctioning of fee levels or particular practices. Mediation involves the expression of opinion by peer review panel members about a fee charged for a particular service provided to a patient. That expression of opinion allows the patient or payer involved to decide whether to pay the fee in question.

Certain guidelines designed to prevent anticompetitive abuse of fee peer review can be drawn from the FTC advisory opinions. These guidelines can be summarized as follows:

(1) Participation in professional peer review of fees is voluntary for the physicians and any complaining or affected party, such as the patient. The FTC is concerned that proffered guidance in fee peer review could become coercive if the process is not voluntary.

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17 *See* Horoschak and See Rule at fn 4 *supra*

18 *"State Medical Boards and Medical Discipline," Inspector General, Department of Health and Human Services (August 1990)*

19 *See Advisory Opinions cited at fn 3, supra*

(2) Determinations made by the peer reviewers about the physician's fees are advisory, and have no coercive aspects. The FTC is concerned that coercive determinations could threaten independent pricing.

(3) Peer review decisions about fees are based solely on the facts and circumstances of the particular case. The FTC is concerned that independent pricing could be threatened if determinations about particular past prices become generalized in future fee peer review opinions.

(4) Peer review decisions about the appropriateness of fees are kept confidential and are not disclosed except to the physician and complaining patient or payer. The FTC believes that dissemination of peer review opinions about fees could threaten independent pricing.[20]

(5) The association of physicians sponsoring professional peer review of fees does not collect information on fees charged by its members and does not use the information to establish a pricing benchmark. The FTC believes that the difficulty and complexity of a procedures should be evaluated based on the individual judgment and expertise of the peer reviewers. To the extent that any reference is made to external factors or benchmarks, consideration should be limited to fee information not sponsored or sanctioned by the medical society.

For the most part, the procedures proposed by the AMA would adhere to these guidelines, but there would be some significant departures. In particular, the proposed process would not be voluntary in all respects. The emphasis of the program would be mediation, but participation would be mandatory for members. Participation would be required because the public would not be well served by a peer review process that members could ignore when patients file complaints about them.

For the same reasons, the program would be coercive in some situations. Medical societies would discipline members who engaged in egregious fee gouging. The purpose would be to give the public confidence that physicians who engage in egregious fee gouging will be held accountable.

The AMA's Proposed Procedures For Peer Review of Fees are Procompetitive

The judicial decisions relevant to peer review of fees are generally consistent with the current policy of the Commission in that they would permit self-regulation activities that do not constitute or enforce a price-fixing agreement. The AMA's proposed procedures for peer review of fees would clearly fall within the range of conduct deemed reasonable by the courts, and any departures from existing FTC guidelines would be procompetitive and lawful.

The Supreme Court has held that an agreement affecting price should only be condemned after a "quick look" to determine whether it has clear anticompetitive consequences and lacks any redeeming virtue. Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., 441 U.S. 1, 19-20 (1979). As noted above, the Commission recognizes the procompetitive benefits that result from peer review of fees. The AMA's proposed fee peer review is thus not inherently suspect; it presents antitrust concerns only if the fee peer review serves to establish or enforce a price-fixing agreement.

The AMA's proposed process contains several elements designed to assure that the peer review conducted will not establish or enforce a price-fixing

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20 *The AMA understands that confidentiality is limited to information about the fee level itself as opposed to the fact of a peer review action. The AMA believes that medical societies may publicize information about the number and nature of peer review actions taken, and could publicize the names of individuals disciplined for fee gouging, provided that the fee amounts involved were not disclosed.*

agreement. First, the PDCs will act on a complaint of alleged fee gouging only (1) when the complaint originates with a patient, or (2) when the complaint originates with another physician and the patient states that he or she either did not agree to pay the high fee, or would not have agreed to pay a fee that was extraordinarily high in comparison to those charged by comparable physicians. Only in extreme circumstances, such as where there is evidence of fraud or a mentally impaired patient, would a PDC pursue fee peer review when the patient is satisfied with the fee charged. This policy limits the possibility that a fee peer review action will be undertaken for the purpose of enforcing a price-fixing agreement among physicians. It would also focus fee peer review activity on those cases in which an imperfect information exchange between physicians and patients has created a distortion in the market which the physician has used to his or her financial advantage.

Second, PDCs will not develop any formal or informal benchmark schedule of reasonable fees with which to resolve fee disputes. Each allegation of fee gouging will be addressed under the unique circumstances in which it arose, and the PDC will simply determine whether the fee charged in that case was excessive. Third, there will be no public disclosure of any fee amounts determined to be excessive, or of the PDC's view of the reasonable fee in each case. These latter two elements limit the possibility that fee peer review will facilitate the development of a price-fixing agreement by physicians.

The Commission has expressed its concern that fee peer review may be used improperly to discipline physicians who compete by offering a new product or service. The substantial due process procedures contained in the AMA's proposal are intended to lessen the possibility of exclusionary conduct under the guise of peer review. The courts recognize that industry self-regulation is usually found lawful when such procedural safeguards are employed. Allied Tube & Conduit Corp. v. Indian Head Inc., 486 U.S. 492 (1988); Silver v. New York Stock Exchange, 373 U.S. 341, 364-67 (1963).

Finally, the Supreme Court's decision in Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982), is not inconsistent with the AMA's proposed process. In Maricopa, the physicians clearly agreed to limit their charges to patients who contracted with a particular insurer. The AMA's proposal involves no such agreement affecting price, and fee peer review is not likely to result in price-fixing. The courts have noted that if an ethical rule is not itself illegal, neither is enforcement of the rule. See, e.g., Vogel v. American Society of Appraisers, 744 F.2d 598 (7th Cir. 1984).

The AMA's proposed procedures for peer review of fees generally adhere to the guidelines developed by the FTC for a procompetitive fee peer review program. The limited ways in which the proposed procedures depart from the FTC guidelines are designed to make enforcement of the ethical rule against fee gouging more effective in a procompetitive manner. These departures actually reinforce the core concepts underlying the FTC guidelines and will not have any anticompetitive effects.

The departures from FTC guidelines in the AMA proposed procedures are as follows:

- Participation in fee peer review by members is mandatory.
- Members who engage in egregious conduct, including fee gouging, may be disciplined.
- Discipline for egregious conduct will not be kept confidential.

Each one of these departures will be discussed below.

a. Mandatory Participation Of Members In Fee Peer Review and Mediation

A primary procompetitive benefit of fee peer review is to provide information to the patient about physician fees and charges. The process helps reduce the disparity of information between physicians and patients. The information helps the patient decide whether to pay all or a portion of the fee in question, and whether to patronize other physicians.[21]

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21 Horoschak, supra, footnote 4

Mandatory participation in fee peer review by medical society members improves the information made available to the patient during mediation. A physician who cooperates with the PGC will provide patient records and other documents, will discuss the physician's perspective about the patient's treatment, and will explain the reasons for the fee. There will be a much better basis upon which to judge whether the fee was reasonable, whether the physician made any mistakes in billing, whether there was a foundation for nonprice complaints by the patient, and other matters.

In addition, the physician receives information from the patient that may help the physician operate a more competitive practice. The physician may find out about office management problems that need to be corrected, about office staff that are not interacting well with patients, or about problems that the physician has in communicating with patients. In addition, the PGC can help inform the physician about educational programs that can help correct the problems revealed during mediation.

Finally, mandatory participation increases the likelihood that settlements acceptable to the patient and the physician can be arrived at. Satisfactory settlements build confidence in the market for physician services. Patients develop confidence that they will be treated fairly, and that they can have complaints resolved.

Mandatory participation in PGC proceedings is not anticompetitive because the focus is on mediation. The only requirement is that the physician participate, not that the physician adhere to any fee or fees recommended by a PGC or the medical society. Further, the physician is not subject to discipline by the PGC for fees charged. (Mandatory participation in disciplinary proceedings conducted by the PDC is discussed below). Participation in remedial education may be required, but only for nonfee aspects of the physician's practice.

b. Disciplines for Fee Gouging

The possibility of PDC discipline for egregious conduct is procompetitive. It provides the patient with information about physicians who have engaged in unconscionable fee gouging or other misconduct. That allows the patient involved and other patients to decide whether or not to continue dealing with the physician. In addition, it builds confidence in the market because patients know that physicians who engage in egregious conduct can be held accountable.

Discipline for fee gouging is not anticompetitive. In most situations, the complaint about an egregious fee will arise out of nonprice conduct such as fraud, the provision of inappropriate services, the provision of substandard services, or other misconduct. Disciplinary actions that are primarily based on such misconduct do not reflect a maximum price fixing agreement.

Even if the discipline concerns fee gouging only, it will not likely reflect maximum price-fixing. Patients who complain about being gouged normally have not agreed, with full information about comparable fees and the quality and need of the service being offered, to pay a fee that is extraordinarily high. Such a patient normally will not have been informed about the extraordinary nature of the fee before receiving the service and, if so informed, would not have agreed to it in advance. Therefore, these are transactions that would not have occurred but for disparities in information between the physician and the patient.

It is unlikely that a patient who, for whatever reason, agreed to an extraordinarily high fee while being fully aware of the fees charged by comparable physicians will file a complaint. Such incidents are likely to be few, and the PDC will address them only in extreme circumstances.

The colleagues of a physician who charges extraordinarily high fees may complain to the applicable medical society. Disciplinary actions that result from a physician complaint about another physician's high fees might reflect enforcement of a maximum price-fixing agreement. However, as discussed above, that possibility can be remedied by restricting discipline to situations where there are patient complaints. If a physician complains about a colleague who charges extraordinarily high fees, a PGC would investigate to determine

whether the physician's patients were fully informed and agreed to pay the fee without being subject to undue influence. If the patients were generally satisfied, there would be no grounds for discipline.

c. Disclosure of Discipline

Finally, publicly disclosing disciplinary actions for fee gouging is procompetitive. It provides information to consumers about physicians who have been charging extraordinarily high fees in situations that have been unfair to patients. That helps patients decide which physicians to patronize, and it builds confidence in the market for physician services.

Moreover, public disclosure of disciplinary actions provides a deterrent effect among the physician community and increases the effectiveness of enforcement of the profession's ethical code.

No information would be disclosed about the fees charged by the physician disciplined or the fees considered reasonable by the PDC. Therefore, disclosure would not constitute a signal about the fee levels that could facilitate a physician fee agreement on fees.

d. Effect on Health Care Expenditures

FTC staff has asked whether the proposed procedures for professional fee peer review will reduce health care expenditures. The AMA cannot promise that precisely discernible savings will result that will be directly attributable to the procedures, but the AMA and the CMS expect that the procedures will help control health care costs. As stated earlier, the program is designed and intended to comply with the antitrust laws and therefore will emphasize the mediation of fee disputes. The program will not, and cannot under the law, be a fee control program which could result in precisely discernible and quantifiable savings. It is expected that the program will reduce the incidence of fee gouging, and therefore result in some directly attributable savings, but fee gouging is not common and its elimination is not expected to result in substantial savings overall. It is expected that the program will help detect and reduce the incidence of fraud, which should also result in cost reductions.

In addition, the information provided to patients through the peer review process will enable them to compare physician fees more effectively, and it will give them a better understanding of medical practice and medical decision making that should make them more effective consumers. The process should also help patients develop a better understanding of what benefits are realistic to expect from physicians, and the extent of the resources that are necessary to provide effective health care. Also, physicians will become more sensitive to the complaints of patients and will change their practice patterns to respond to them. The result of more informed consumers and more sensitive physicians should be an improved market.

Conclusion

For the reasons stated above, the AMA and CMS believe that the AMA's proposed fee peer review procedures will be procompetitive and facilitate the operation of the market for physician services. Equally important, the procedures will enhance the protection of patients where the market does not operate efficiently and thereby increase the trust of patients in their physicians, which is the heart of the physician/patient relationship. The AMA and CMS request an opinion that the proposed procedures are not anticompetitive and would not be subject to FTC enforcement actions.

Sincerely,

Kirk B. Johnson, General Counsel
Edward Hirshfeld
American Medical Association

John M. Peterson (DZ)

John M. Peterson
Howe & Hutton, Ltd.
Counsel for Chicago Medical Society

Senator METZENBAUM. Thank you very much.

Mr. Bruce Brennan, speaking on behalf of the Pharmaceutical Manufacturers Association. We are happy to have you with us today, sir.

STATEMENT OF BRUCE J. BRENNAN

Mr. BRENNAN. Thank you, Senator. Mr. Chairman, Mr. Hatch, I have with me also today, Senator, Mr. Thomas Downs from the Washington law firm of Swidler & Berlin, our association's outside antitrust counsel.

Senator METZENBAUM. We are happy to welcome him.

Mr. BRENNAN. We are both pleased to be here on behalf of PMA to talk about antitrust concerns in the health care area.

In recent times, there has been a growing concern in the United States over the rising costs of health care, including the cost of prescription drugs. The PMA and its members have been and are desirous of participating in the effort to contain such costs. At the same time, PMA and its members believe it is vital that, in seeking a solution to the rising cost of health care, the Nation preserve the free market and competitive principles upon which that market relies. That market and those principles are not only at the heart of this subcommittee's jurisdiction, but they form the foundation on which the U.S. pharmaceutical industry has achieved world leadership.

The fundamental role of the pharmaceutical industry is clear, to develop new and improved products that will enhance our ability to prevent, treat, and hopefully cure disease, and to do so at costs that are lower than nonpharmaceutical alternatives. But the development of new and improved products is both expensive and highly risky. Those essential activities will neither be funded nor even undertaken in the absence of marketplace conditions providing necessary incentives. At the same time, the products of the pharmaceutical industry must be available to those in need.

It is important for these reasons, the need for an environment supportive of innovation and the requirements of fairness and availability to patients, that the PMA and its members have supported a national program of managed competition in health care and the extension of insurance coverage to prescription drugs. But today for a large percentage of Americans, these programs are not yet in place and it may be some time before they are. In the interim—and I stress the interim—the PMA and its member companies are prepared to act to contain the cost of prescription drugs.

Let me take us up to the present. In the fall of 1992, the association adopted a resolution instructing its president to meet with representatives of the incoming administration and Members of Congress to inquire whether there existed any interest in exploring with individual member companies their willingness to limit aggregate price increases to increases in the CPI or some other index. The full text of that resolution and the efforts made by the association in furtherance of its declared objective are reviewed in the association's March 12 request for a business review letter that we filed with the Antitrust Division.

While the association's resolution has been praised by many, it has neither been adopted nor rejected by the administration to

date. Given the commitment of the association and its members to demonstrate their interest in providing construction solutions, the association determined to take the next step. That next step cannot, however, be taken without a favorable response to our request from the Antitrust Division.

The subject at issue in the request is prices and the action contemplated requires some measure of agreement, however limited. The antitrust laws preclude even that limited agreement without the assurance of the Division that it will not prosecute either criminally or civilly should the association and its members act in accordance with the request.

Now, since filing that request we have been asked why did we not seek legislation granting immunity under the antitrust laws. There are three important reasons. First, we are committed to competitive marketplace, subject over the long term to the disciplines embodied in our antitrust laws. Thus, we do not seek permanent protection from either the forces of competition or from the laws that protect such competition. Accordingly, our request seeks only interim protection pending adoption of the Government's program of managed competition.

Second, responding to the stated concerns of senior Government officials for action now pending adoption of the Government's program, the legislative alternative would not appear timely. And, third, we do not advance our request believing that it constitutes a comprehensive response to all the many questions that may be or have been raised concerning the cost of prescription drugs. Our proposal represents an earnest, meaningful and good-faith effort to address the issues pending the Government's program for managed competition.

We have also been asked why, as an alternative to the request, individual member companies could not just take the same or similar action as that that has already been taken by 10 of our members who, acting unilaterally, have declared publicly their intention to limit future price increases in much the same manner as that contemplated in our request.

The short answer is nothing precludes that undertaking by others acting individually. Yet, that answer will not withstand examination. If self-restraint is to be credible even as an interim measure, there must be some agreement on basic principles. Thus, the term "net prices" must be defined in language that is common to all companies. There must be a uniform procedure for reporting. The Government must be afforded a meaningful opportunity for determining compliance with a voluntary program. So, too, as some Members of Congress have urged, there must be an enforcement mechanism.

Now, all of these subjects are addressed in the undertaking described in our request. Of course, nothing prevents individual companies from imposing even more serious or severe limitations on their pricing behavior than is contemplated in the request. If approved and adopted, the undertaking sets forth a ceiling on price increases, but it does not set a floor on either price containment or price reduction.

Finally, Mr. Chairman, on behalf of the association and its members, I wish to reiterate that our request to the Antitrust Division

has been made in the utmost good faith. As an interim measure for dealing with prescription drug prices, we feel it is entitled to serious and, we think, favorable consideration. Also, as an interim measure, we think it is superior to other interim measures advanced, including price regulation or price freezes. Those alternatives would stifle innovation, we feel, and preclude the acquisition of capital essential to our research and development.

If this committee concurs with us on the merits of our request, we would urge and hope that the committee would so advise the Antitrust Division.

Thank you.

[The prepared statement of Mr. Brennan follows:]

PREPARED STATEMENT OF BRUCE J. BRENNAN ON BEHALF OF THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION

Mr. Chairman and members of the Subcommittee: I am Bruce J. Brennan, Senior Vice President and General Counsel of the Pharmaceutical Manufacturers Association. PMA represents more than 100 research-based pharmaceutical companies that discover, develop and produce most of the prescription drugs used in the United States, and a substantial portion of the medicines used abroad. I appreciate the opportunity to appear before the Subcommittee today to present the industry's views on antitrust issues in the health industry.

In recent times, there has been a growing concern in the United States over the rising cost of healthcare, including the cost of prescription drugs. The PMA and its member companies have been and are desirous of participating in the effort to contain such costs. At the same time, the PMA and its members believe that it is vital that, in seeking a solution to rising costs for healthcare, the nation preserve the free market and competitive principles on which that market relies. That market and those principles are not only at the heart of this Subcommittee's jurisdiction, but form the foundation on which the U.S. pharmaceutical industry has achieved world leadership.

In the current consideration of healthcare reform, there are some factors about the U.S. pharmaceutical industry that are not being recognized by many policymakers and segments of the public.

- *Price increases have slowed.* According to the Bureau of Labor and Statistics (BLS), manufacturers' price increases for prescription drugs for the 12-month period ending in January were the smallest in 15 years. They have declined steadily since 1989, dropping from 9.5 percent in that year to 4.5 percent during the 12 months ending in February—a 53 percent decrease. And because of economic analyses showing that the BLS index actually overstates price increases, BLS is changing its methods for measuring pharmaceutical price increases.
- *Companies are voluntarily holding down prices.* Ten companies representing more than 40 percent of U.S. sales have independently pledged to keep prices at or below inflation—and all are honoring their pledges.
- *Pharmaceuticals are not a key factor in the rapid rise in total healthcare expenditures.*

  —Outpatient prescription drugs as a percent of national healthcare expenditures have declined in the U.S., dropping from 8.9 percent in 1965 to 4.8 percent in 1991.

  —While healthcare costs have increased rapidly, rising from 5.9 percent of GDP in 1965 to 13.2 percent in 1991, the share of GDP spent on prescription drugs has remained relatively constant for three decades—at 0.53 percent of GDP in 1965 and 0.64 percent in 1991.
- *New drugs are entering the market at prices lower than the prices of existing market leaders.* Of new chemical entities which were approved by the FDA for marketing in the U.S. during 1991 and 1992, 24 of these were launched into therapeutic areas where competing pharmaceuticals existed. In these cases, 21 of the 24 entered the U.S. market at a price lower than the price of the existing market leader. In many cases, these prices were substantially lower, averaging 18 percent lower for pharmaceuticals treating chronic ailments, and 7 percent lower for pharmaceuticals treating acute ailments.

While the PMA and its members do not take issue with the need for a national program for containing healthcare costs, any such program must take account not only of the forces and entities that have contributed to the rising costs of healthcare, but of the historical and potential future role in containing overall costs that each participating segment may play. In the case of the pharmaceutical industry, that future role is plainly revealed in the record of its past performance: The products of our industry, considerations of prescription drug prices included, have contributed not only to the prevention, treatment and cure of disease, but also to the opportunity to treat people as out-patients who otherwise would require expensive in-hospital care. Overall, the products of the pharmaceutic industry have served to contain, rather than to increase, healthcare costs in the United States. Prescription drugs are the most cost effective alternative to the prevention, treatment and cure of disease.

Looking to the future, and assuming government policies that are supportive of innovation, the fundamental role of the pharmaceutic industry is clear: To develop new and improved products that will enhance our ability to prevent, treat and, hopefully, cure disease and to do so at costs that are lower than non-pharmaceutical alternatives. But, the development of new and improved products is both expensive and highly risky. Those essential activities will neither be funded nor undertaken in the absence of market-place conditions providing necessary incentives. At the same time, the products of the pharmaceutical industry must be available to those in need. It is for these reasons—the need for an environment supportive of innovation and the requirements of fairness and availability to patients—that the PMA and its members have supported a national program of managed competition in healthcare and the extension of insurance coverage to prescription drugs. But, today, for a large percentage of Americans those programs are not in place, and it may be some time before they are. In the interim, the PMA and its member companies are prepared to act to contain the costs of prescription drugs.

In the fall of 1992, the Association adopted a Resolution instructing its President to meet with representatives of the incoming Administration and Members of Congress to inquire whether there existed any interest in exploring with individual member companies their willingness to limit aggregate price increases to increases in the CPI or some other index. The full text of that resolution and the efforts made by the Association in furtherance of its declared objective are reviewed in the Association's March 12th *Request for Business Review Letter* to the Antitrust Division of the Department of Justice, copies of which were earlier provided to the Subcommittee's staff. As you are aware, while the Association's resolution has been praised by many, it has neither been adopted nor rejected to date. Given the commitment of the Association and its members to demonstrate their interest in providing constructive solutions, the Association determined to take the next step.

That next step cannot, however, be taken without a favorable response to the Request filed with the Antitrust Division. The subject at issue in the Request is prices and the action contemplated requires some measure of agreement, however limited. The antitrust laws preclude even that limited agreement without the assurance of the Division that it would not prosecute, civilly or criminally, should the Association and its members act in accordance with the Request.

While I would be happy to respond to questions concerning the substance of the Association's request, I do not propose to take up your time by restating it here. Rather, I will address issues that will shed greater light on why the Association made the request, as against pursuing other possible alternatives.

Since filing the Request, we have been asked why we did not seek legislation granting immunity under the antitrust laws? There are three important reasons. First, we are committed to a competitive market place subject, over the long term, to the disciplines embodied in our antitrust laws. Thus, we do not seek permanent protection from either the forces of competition or from the laws that protect such competition. Accordingly, our Request only seeks interim protection pending adoption of the Government's program of managed competition. Second, responding to the stated concerns of senior Government officials for action now pending adoption of the Government's program, the legislative alternative would not have proved timely. And third, we do not advance our Request believing that it constitutes a comprehensive response to all of the many questions that may be and have been raised concerning the costs of prescription drugs. Our proposal represents an earnest, meaningful and good faith effort to address the issues pending the Government's program for managed competition.

We also have been asked why, as an alternative to the Request, individual member companies could not take the same or similar action as that already taken by 10 members who, acting unilaterally, have declared publicly their intention to limit future price increases in much the same manner as that contemplated in the Re-

quest? The short answer is that nothing precludes that undertaking by others acting individually. Yet, that answer will not withstand examination. If self restraint is to be credible even as an interim measure, there must be some agreement on basic principles. Thus, the term "net prices" must be defined in language that is common to all companies; there must be a uniform procedure for reporting; and the Government must be afforded a meaningful opportunity for determining compliance with this voluntary program. So too, as some Members of Congress have said to us, there must be an enforcement mechanism. All of these subjects are addressed in the undertaking advanced in our Request. Of course, nothing prevents individual companies from imposing more severe limitations on their pricing behavior than are contemplated in the Request. If approved and adopted, the undertaking sets a ceiling on price increases, it does not set a floor on either price containment or price reduction.

The discussion above clearly indicates that PMA and its members have made every effort possible under the law to address concerns about pharmaceutical product costs in a responsible manner. But the law prevents us from taking certain steps or even engaging in dialogue on the subject of pharmaceutical product prices. A good example occurred in December 1992 when we received from then President-elect Clinton's Transition Team a series of questions about the pharmaceutical industry. Approximately one-third of those questions dealt with the prices of existing products and mechanisms for curtailing price increases in the future. We responded to those particular questions in the following manner:

> To the extent that the antitrust laws permit, PMA is attempting to address in the near future the issues raised in these questions, and we hope to deal with them in close cooperation with the incoming Administration through an appropriate and lawful mechanism. However, we are not able to answer them in this response.

The Request, which I've just discussed, is our sincere effort to develop such a lawful mechanism for our addressing with Government these critical issues.

Mr. Chairman and Members of the Committee, I will do my best to answer your questions. On behalf of the Association and its member companies, I wish to reiterate that our Request to the Division has been made in the utmost good faith. As an interim measure for dealing with prescription drug prices, it is entitled to serious and, we think, favorable consideration. As an interim measure, it is superior to other interim measures advanced, including price regulation or price freezes. These alternatives would stifle innovation and preclude the acquisition of capital essential to research and development. If this Committee concurs with us upon the merits of our request, we would hope that you will so advise the Antitrust Division.

Thank you.

Senator METZENBAUM. Thank you very much. This is a very interesting panel, and the Chair finds it very interesting that the Clinton administration is entitled to a lot of credit for advancing the discussion of this entire subject and putting it on the table and indicating it is going to come forward with a program, and I think that all three of your groups have entered the dialog with the administration. Is that correct for the Hospital Association?

Mr. ENTIN. That is correct, Senator.

Senator METZENBAUM. And also for the AMA?

Dr. CORLIN. Certainly.

Senator METZENBAUM. And also for the PMA?

Mr. BRENNAN. Yes.

Senator METZENBAUM. I don't know what the bottom line will be. Each of you makes your own argument. My own feeling is that in some instances "methinks he doth protest too much." I think in some instances your proposals have to be suspect.

Dr. Corlin talks about these agreements, but reserving the rights to the doctors with respect to five separate items, one of which was reimbursement. Well, that would mean collective action as to reimbursement decisions. The PMA proposal—the Chair has many concerns about that because we think that the proposed minimums

can be used in such a way as to be maximums; that when you have an agreement of this kind, there is no reason to assume that the coordinated effort is actually going to bring down prices. The individual companies are certainly in a position to bring down prices on their own.

I know that you are aware of the fact, Mr. Brennan, that Senator Pryor and I have addressed a communication to the Department indicating our concerns about your proposals because we think that you can do the very same thing without a coordinated effort and that if you were to do it, it would redound to the public's interest more effectively.

Having said that, let me proceed forward with a few questions, but I do think that we now find that this entire subject is on the table, and for that the President and the First Lady, Hillary Rodham Clinton, are entitled to considerable credit.

Mr. Entin, in your written testimony you state that some collaborative activities that would be beneficial to patients and purchasers of health care are clearly prohibited under current antitrust law. The example you give is that the antitrust laws prohibit market allocation agreements where hospital competitors decide which one will buy an MRI and which one will buy a lithotritor.

I don't share your view that patients would be better off if we let hospital competitors carve up the market. There can be ulterior motives, there can be good motives. But even among hospital competitors for those kinds of agreements, just because it looks on its face as if it might be correct to have one buy the MRI and one buy the lithotritor, it doesn't necessarily mean that it works out well for the patient. For example, hospitals could agree to let one another become the exclusive provider of a technology or service for the purpose of monopolizing that market and charging higher prices.

Is it AHA's position that the antitrust enforcement authority should allow hospital competitors to divide up a market for the purpose of monopolizing a particular technology or service, and if not, how would you suggest that the authorities distinguish between an anticompetitive market allocation scheme and one that will benefit patients? Should some hospitals deal only with cardiovascular matters and some with gastroenterology matters? Would that be appropriate?

Mr. ENTIN. Well, I can answer that question, I think, in two parts, Senator. I think, first, our comments in our written testimony with regard to allocation really are addressing a problem that many have commented on is a problem with a current health care system, and that is we have too much technology in certain communities where it is redundant and where it is inefficient. Where it is inefficient and where it is underutilized, there are costs that must be borne by those health care providers in those communities which get passed on and result in waste of assets.

So to the extent that we have communities in which we have to eliminate capacity which is no longer needed, then some form of agreement within that community needs to be entered into in order to do that. I believe, as I understand the antitrust laws currently, those agreements may be illegal.

Senator METZENBAUM. I understand that point, but how about my question?

Mr. ENTIN. Well, the second part of that question with regard to whether or not it would benefit consumers can also be answered with regard to the utilization question as well. There are studies that demonstrate that certain technologies and certain procedures are done better, more effectively, more efficiently, and therefore with higher levels of quality when the procedures are concentrated in one location or another rather than having them spread and done sporadically across a community.

So a second part of my answer to your question, Senator, would be that the communities would benefit to a great extent in the improvement of quality as a result of concentration of certain technologies in limited numbers of locations.

Senator METZENBAUM. Undoubtedly, you are aware that press reports have suggested that there is a conflict between what your lobbyists are telling Congress and what you say to your own members about hospital merger deals. For example, Modern Health Care, a respected industry publication, has charged that "the AHA is telling its members to pursue collaboration because the antitrust laws won't punish beneficial arrangements." It goes on to say, "but it is telling lawmakers to change the antitrust laws because they may bar beneficial collaborative ventures."

In addition, statements by your own officials indicating that hospital deals are flourishing suggest little concern about the chilling effect of antitrust enforcement. For example, in a December 1991 interview with Health News Daily, your president, Richard Davidson, referred to the problems created by antitrust enforcement as more a perception than a reality. He also stated that the whole thing has been blown out of proportion.

How do you explain your own president's enthusiasm about the pace of hospital collaboration and his apparent lack of concern about antitrust enforcement in light of your testimony that antitrust enforcement is chilling hospital deals?

Mr. ENTIN. Well, let me go back to my oral testimony, Senator. If you recall, I indicated that we believe there are three dimensions to the problem, and certainly with regard to those collaborative activities which bear little or no antitrust risk, if there is concern about those, it is a matter of perception and it is an erroneous perception. We have worked with our membership to explain to them how far the law does apply and where it reaches and where it does not, and we have encouraged them to enter into collaborative activities.

That is what Mr. Davidson is referring to when he says it is beginning to flourish. We have been urging our members for the last 1½ to 2 years to abandon cutthroat competitive strategies and look for ways to work with other providers within their community to deliver a more rational way of providing health care services.

Senator METZENBAUM. If the AHA were asked by a group of hospitals in a particular community, we are thinking of working together to develop a gastroenterology operation exclusively and we will specialize in that, the other hospital will work in cardiovascular situations and the other will operate in thoracic surgery

or something of the kind—I am not sure what groupings would be appropriate—what would the AHA say to them about that?

Mr. ENTIN. I think it would be consistent with the message that we are giving, but what we would certainly have to analyze is whether or not concentrating those services in those specific facilities is going to provide the full range of services that are necessary for the population. But if, in fact, the outcome of that type of agreement is to reduce excessive services, reduce capacity, and improve quality, then we certainly would favor those kinds of discussions and agreements.

Senator METZENBAUM. Dr. Corlin, in your testimony you suggested that the Arizona dentists who were prosecuted by the Antitrust Division in *United States* v. *Alston* were engaging in procompetitive behavior. In that case, upwards of 30 dentists agreed to raise and to fix the out-of-pocket copayment fees that their patients with insurance had to pay. The dentists wrote identical letters to dental plans and the letters said, we will not accept in our office copayment schedules less than the ones submitted with this letter. In other words, the dentists refused to treat the plan's patients unless their demands for higher copayments were met. The dentists were convicted of price-fixing. A former head of the Antitrust Division, James Rill, called the *Alston* case a prime example of per se illegal conduct warranting criminal prosecution.

How can the AMA justify the Arizona dentists' price-fixing agreement as procompetitive?

Dr. CORLIN. Senator Metzenbaum, the AMA does not endorse the Arizona dentists' actions. However, I believe that some of the impact of that case and some of the facts of that case have been misstated.

The issue before Alston and the other dentists was not copayment in the normal manner that we think of copayment for insurance, in that, you know, you have $10 per visit or we pay 80 percent and the copayment is 20 percent. The facts here were that there was a dental plan that said that these things we cover and this is what we pay. This particular service, we don't cover it all; we won't pay anything at all, but this is what the dentist should charge. It was not an issue of the plan paying a certain amount of money.

What Dr. Alston and the other dentists said was, in Phoenix, the generally recognized charge is substantially more and they simply said to the dental plan, we would like to be paid what the dentists in Phoenix were paid. I believe Dr. Alston and the group of dentists are in Tucson. They never boycotted, they never refused to treat the patients. It was simply a coordinated request of the plan to say, for a charge that you don't cover we think you should state what the fees should be more realistically.

Second, the Government held a large press conference at the beginning of the *Alston* case, spent many years and at least hundreds of thousands of dollars, if not millions of dollars, to prosecute Dr. Alston and 30 other dentists in order to wind up with a $3,000 penalty. I hardly think the amount of legal resources expended were appropriate to get a $3,000 fine.

Now, let me conclude by saying we do not endorse any sort of boycotts or threats, but we don't think any occurred here. More

than that, Senator, I am concerned with the impact on non-economic issues that antitrust has, and I would like to give a couple of examples.

The California Medical Association for decades published something called the Medical Opinion Letter. It was not a socioeconomic publication. As new and emerging technologies came to be, we would ask people, usually academics, to write a monograph on this topic, whatever it was, explaining the status of development of this new field and whether or not, number one, it was proven to be helpful and, number two, even if it was proven to be helpful, should it yet be considered a legitimate clinical treatment for which insurance companies should pay or should it still be considered experimental and we ought to wait.

One of the things that we asked to have reviewed—two of them—one was urine injections. There were some doctors in California—California does some screwy things—there were some doctors in California doing urine injections, claiming that they treated God only knows what. Rather than simply react viscerally, we sent this out to a panel of academics who reviewed the literature and concluded that there clearly was no legitimate basis for injecting patients with their own urine.

We published this opinion. We didn't say we are going to kick anybody out of membership if they do it. It was simply we published an opinion saying this is worthless. The resulting lawsuits privately brought against the California Medical Association were such that we have had to suspend publication of that document which provided a benchmark for what is legitimate treatment, which saved insurance companies and patients millions of dollars over the years.

There was a similar case previously of some doctors who were operating to cut certain nerves in the neck, claiming it cured asthma. A review of that showed it was worthless. Again, a lawsuit was brought.

Senator METZENBAUM. I don't see those as antitrust issues, though.

Dr. CORLIN. Well, they were brought claiming that they were anticompetitive. In addition to that, in my own hospital, in my own gastroenterology section, we had one doctor who was the subject of many complaints and we were concerned about his quality. We had a special committee privately review many of his cases and concluded that some of his privileges should be restricted.

His response was neither admitting he needed more training or defending his behavior, but his response was to file a response that we were only interested in restricting his ability to get patients so that we could steal his patients from him.

In the real world, the threat of an antitrust case chills disciplinary behavior, and whereas our lawyers in every other case—not just ours, but lawyers in general—say conduct yourselves so that if you are sued you will win, when it comes to antitrust cases the advice is you can't even afford to defend this case, avoid the issue. That unfortunately is what really happens, and if there is a perception problem it is as broad as from New York to California.

Senator METZENBAUM. Thank you very much.

Senator Thurmond?

Senator THURMOND. Thank you very much. Mr. Entin, do you believe that additional guidance from the antitrust enforcement agencies about the legality of mergers and joint ventures, along with the proposals of Senator Cohen for hospitals to share medical technology and services in appropriate circumstances, would be sufficient to address your concerns?

Mr. ENTIN. I think they would go a long way toward addressing our concerns, Senator. We would certainly applaud Senator Cohen's legislation as a positive toward assisting collaboration and reform. With regard to getting much more specific and concise guidance from the agencies, specifically those that address the questions of efficiencies, a great deal can be saved in terms of the difficulty that our members have in getting clean and concise advice from their counsel.

But ultimately, Senator, there still may remain a problem in those communities that have excessive capacity, and in those areas there may be the need for some legislative relief in order to allow for agreements to eliminate some of that capacity.

Senator THURMOND. Do you believe there is any need for competition between hospitals in order to hold down prices and keep quality high, or do other factors accomplish these goals?

Mr. ENTIN. I think there are many factors that enter into health care. Competition certainly can affect price and quality, but as we point out in our white paper and in our testimony, there are many other factors present in this segment of the economy which we don't believe allow the traditional economic paradigm to really work well when it comes to health care. I think there are many other considerations that make it not fit well.

Senator THURMOND. Dr. Corlin, you stated that the AMA is not seeking any exemption from the antitrust laws for price-fixing. I believe that is correct.

Dr. CORLIN. Yes, sir.

Senator THURMOND. However, the AMA's proposals for independent physicians to negotiate collectively or to use joint marketing arrangements might be viewed by some as illegal under the antitrust laws. If so, would the AMA seek an exemption for such activities in order to be able to participate more effectively in the health care field once it is reformed?

Dr. CORLIN. I will give you part of the answer and for some of the technical things I would like your permission to have Mr. Johnson give some of the rest of it. We are not asking that physicians be allowed collectively to set the price. Physicians aren't price-setters anymore; they are price-takers.

Even in my own community of Santa Monica, which is one of the upper-end parts of Los Angeles, only 15 percent of the fees are set by the physicians; 85 percent of the fees are set by the payers.

Senator THURMOND. Are set by who?

Dr. CORLIN. The payers. The insurance companies, the HMO's, the businesses, or the Government sets the fees for 85 percent of our patients. We do believe that physicians being able to respond to give coordinated input to these plans is much more meaningful and appropriate than individual responses that would be given to these plans.

If I may, I would like to ask Mr. Johnson to amplify on that.

Mr. JOHNSON. Senator Thurmond, we do not believe we need an exemption. Prior interpretations of the antitrust laws by the Justice Department have permitted the very thing that we are asking to have clarified today that when groups of physicians who don't have market power, because there are only 10 or 15 or 20 percent of them in the market, get together, create some efficiency—joint marketing; they have a panel of good physicians, they agree to utilization review or other efficiencies—they can agree on a schedule to propose to a payer, frequently a payer that controls hundreds of thousands of their patients' lives, in competition with other groups, whether it is an insurance company or an HMO or other groups of doctors.

We just want these physicians as a step—the next step may be full integration, but to take the step from where they were before, very independent, unconnected entirely, figure out a way to provide service that an employer might want, and to be able to present it. If the employer says, no, I don't think this is what we want, we would like a capitated system, these physicians are going to go back and rethink their organization. But they ought to have a chance to do that.

The Justice Department in the past has indicated there are efficiencies that are procompetitive. We don't have that clarification today. Antitrust lawyers are saying to doctors who want to begin this process which may end up in integration, don't do it.

Senator THURMOND. Dr. Corlin, would the AMA's proposals hold down costs for consumers or are the proposals primarily focused on maintaining or improving the quality of our health care system?

Dr. CORLIN. I think that they would do both, Senator Thurmond, and in taking a look at health care costs there is a difference between what is the doctor's fee and what is the health care cost. Some of the systems that we operate in are fee for service on a prearranged fee schedule, some of them are capitated plans, but all of those fees have at the core of their efficiencies not so much discounting of the individual bill, but utilization review to reduce the number of days the patient spends in hospital, to reduce the numbers of units of service delivered.

We believe that taking a look not just at the dollars, but what else does the system do, in some circumstances saying that the lowest cost per hospital visit or cost per delivery may not be the lowest cost of the operation of the system is important to realize.

I think if we take a look at what medicine is like and how it is practiced now compared to 30 years ago, we find some interesting circumstances. A woman with an uncomplicated delivery is often in and out of the hospital in 24 to 36 hours; a cesarean section, 48 to 72 hours. Gall bladders are removed often without the patient even checking into the hospital in many areas in Southern California. There is a facility opening in my town within a year when its construction is completed that will do hysterectomies on an out-patient basis.

We need to take a look at the entire operation of the system to say how can it save money, not just say the one that pays the least for this service is the most efficient one. Now, I am not saying that to evade getting at what are doctors paid or hospitals paid, but I am saying that we need to take a look at more than just what are

the dollars per visit per day in the hospital. We need to take a look at what else is the system providing.

To me, when I take a look at the efficiency of a system—and I headed up the IPA at my hospital for 2 years—when I take a look at the efficiencies of the system, I take a look first at what does the utilization review do, how many days per thousand patients in the hospital is the track record for this system, because I know that is going to save me a lot more money than $3 or $5 on an office visit or $100 on a surgery.

Senator THURMOND. Mr. Brennan, do you think your proposal would diminish competition among pharmaceutical manufacturers in any way?

Mr. BRENNAN. Senator, our proposal won't diminish competition among pharmaceutical manufacturers in any way whatsoever. In fact, it would maintain competition throughout the pharmaceutical industry. What we suggested to the administration as a group of voluntary undertakings by companies and we are now suggesting to the Department of Justice for an agreement among companies is to limit price increases across a product line, not with respect to individual products. So companies would still have complete flexibility within their product line to price their products competitively against the other manufacturers.

Senator THURMOND. Mr. Brennan, the Clinton administration seems to be contemplating price controls in the absence of voluntary industry action to limit prices. Is your request for a business review letter intended to address such concerns?

Mr. BRENNAN. Well, our request for a business review letter, Senator, is an alternative to any suggestion of price controls or mandatory governmental price restraints. Price controls would turn an industry like the pharmaceutical industry into a regulated utility and we think would have a disastrous effect on the incentives for continuing research and development.

Senator THURMOND. Mr. Brennan, last week the Washington Post featured a story in its health section entitled "Running Out of Wonder Drugs: 50 Years after the Advent of Penicillin, Doctors Fear Antibiotics Are Losing Their Punch." Do such concerns relate in any way to your proposal?

Mr. BRENNAN. Senator, if our proposal is adopted and the pharmaceutical industry continues to be able to operate in a free market, we think our member companies are going to continue to invest the billions of dollars they are currently investing in research for new medicines, and the pipelines for these companies are really exciting. There are some great new therapies just over the horizon and our companies, as I said, are investing billions of dollars in the pursuance of those therapies.

Senator THURMOND. Dr. Corlin, I want to ask you a personal question.

Dr. CORLIN. Yes, sir.

Senator THURMOND. I have four children, two boys and two girls. They have been considering studying law and studying medicine. Why should they study medicine? [Laughter.]

Dr. CORLIN. Let me expand on the answer I will give to that because you hear these alleged stories of doctors saying I am going to tell my children not to go into medicine anymore. I happen to

think that the practice of medicine is the most rewarding thing I could ever imagine. I completed my training in 1972. I spent 3 years on the faculty at UCLA. I have been in private practice since then. It is a wonderful experience for me.

I have four partners. We do well by it, to be sure, but we don't do it for that. In fact, most of us, as well as we do—if I had gone into real estate, I probably would have made more money than I am making now. Of course, the real estate market in California, not this year, but it is a wonderful experience. It is incredibly enjoyable, the ability to treat patients and get positive responses.

If I can give a personal response——

Senator METZENBAUM. I am going to ask you to wind up.

Dr. CORLIN. If I can give a personal response, I had a patient come in to me who was a 20-some-odd-year-old construction worker. He was operated on to have his appendix out and there was a complication and he had to have half of his small intestine removed. As a result of that, he had disabling diarrhea 25 times a day. There is a good physiologic reason for it. He was from a rural community. He had to stop working, he had to go on welfare. He was married and had two children.

He was sent to me in consultation. I was the first gastroenterologist he saw. There is a medicine on the market that I was able to start him on. It has no significant side effects, it will have lifelong benefits. Within 48 hours, he was having two well-formed stools a day. Within 6 weeks, he was back to work, he was off welfare. That is perhaps an extreme example, but it is a wonderfully rewarding way to conduct one's life and I wouldn't have traded it for anything.

Senator HATCH. We need you around here. [Laughter.]

Another testimony to the pharmaceutical industry is all I can say.

Senator THURMOND. Mr. Chairman, just give me half a minute.

Senator METZENBAUM. Sure.

Senator THURMOND. Now, I have got several nephews that are doctors. They are complaining about the high insurance they have to pay as obstetricians and surgeons. Now, what can we do about that? What can we do to reduce the cost, which comes eventually from the patients?

Dr. CORLIN. Yes, sir. You know, California——

Senator THURMOND. Are you all recommending something to stop unnecessary litigation that is causing all this expense?

Dr. CORLIN. California, Senator, has been stated to have contributed two things to American culture. One is the ability to make a right turn on a red light and the other is MICRA. I believe that California for 17 years has had the gold standard for tort reform, which includes a cap on noneconomic damages, waiver of the collateral source rule, periodic payments, and limits on contingency fees.

As a result of that, malpractice insurance premiums in California today, in actual dollars, not inflation-adjusted dollars, but in actual dollars, are virtually the same as they were in 1975. I believe Senator Hatch has particular familiarity with those provisions, and the AMA most certainly hopes that as we take a look at all aspects of health reform, and recognizing that between malpractice premiums for doctors and hospitals and defensive medicine that those three

things add about $40 billion to our health care costs, we certainly hope that the MICRA-type provisions modeled after those in California become a part of the health care reform that we have.

Senator THURMOND. Do we need Federal or State laws on the subject?

Dr. CORLIN. I believe we need State laws, but what I would like to see is something analogous to what the Federal Government did with the highway money and the 55-mile-an-hour speed limit where you have the ability to pass a very strong incentive—that is, the Medicaid matching money—to encourage the States to pass this component to help control medical care costs.

Senator THURMOND. Thank you very much.

Senator METZENBAUM. Dr. Corlin, do you want to tell Senator Thurmond that the malpractice insurance rates in California indeed are not lower than they are throughout the rest of the country?

Dr. CORLIN. Excuse me?

Senator METZENBAUM. Your rates in California are not lower than they are throughout the rest of the country, are they?

Dr. CORLIN. Yes, sir, they are, and particularly if you compare California with the other large industrialized States, they are substantially lower. Two examples are an internist in Los Angeles will pay approximately a third of what an internist will pay in Miami, and a neurosurgeon in Los Angeles will pay only $42,000 a year, whereas a neurosurgeon in Miami will pay something in excess of $150,000.

Senator METZENBAUM. Well, but you are comparing Miami. How about in Boston, how about in Cleveland?

Dr. CORLIN. California is substantially lower than most other industrialized States. I don't have all the figures because I was not aware that these questions were going to come up. We can certainly provide them. But as one example, Senator, prior to passing MICRA in 1975, the malpractice rate for obstetricians in California was 50 percent higher than the national average. Today, the malpractice rate for obstetricians is approximately 30 percent lower in California than the national average. It has been an effective law.

Senator METZENBAUM. We will get into that in another hearing.

Dr. CORLIN. Yes, sir.

Senator THURMOND. I want to thank all of you for your appearance here.

Senator METZENBAUM. Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman. I would like each of the witnesses to take a crack at this question, which concerns the certainty that most health care reforms will require market reform. I am going to start with you, Mr. Entin. I would like you to elaborate on the types of antitrust reforms you believe will be necessary for your industry to allow possible efficiency savings to be passed on to your consumers.

Mr. ENTIN. The core of reform proposal is to put together networks of providers, and we are not just talking about hospital-hospital collaboration; we are talking about integrated networks of all providers. To the extent that the antitrust laws get in the way of network formation, I believe there needs to be some relief.

I believe the current antitrust laws, however, Senator, do allow for many forms of collaboration. Were we to get to the end point——

Senator HATCH. They can be arbitrarily applied.

Mr. ENTIN. They can be arbitrarily applied, and that gets us to the question of getting more clarity and concise guidance. The antitrust agencies right now under their enforcement policies would seem, if you look at their guidelines, to need to go against the majority of collaborative activities in those communities that have six or fewer hospitals, I think, as you brought out.

If, in fact, they are not bringing those, then what guidance we would need is to understand why, in fact, those actions have not been brought and what are the criteria and what are the bases upon which those decisions not to challenge have been made. I don't believe that requires a change in the law. However, the law would have to be changed with regard to making rational decisions about allocating existing resources in certain communities.

Senator HATCH. Dr. Corlin?

Dr. CORLIN. I also think that we ought to foster the development of a variety of innovative and collaborative approaches, and we have on the scene today PPO's, IPA's, HMO's. We look to be having AHP's, and HIPC's. I am not sure that the last story has been written. There may be some other proposal out there that we are not yet aware of that may have some greater innovation.

As we take a look at these new proposals, recognize that none of them can be put in place by an individual physician and that it is not practical in circumstances for doctors to organize into a solitary group because there may be many different proposals that will affect different physicians differently, and I would hope that we could have some flexibility in approaching these new collaborative arrangements.

Another area to be looked at which we haven't yet mentioned today, and it does carry with it potentially severe antitrust considerations, is to take a look at manpower and specialty distribution circumstances. Two-thirds of the training programs in this country are specialty, and I don't think anybody will say that that meets the needs of our population. Yet, individually, everybody is afraid to jump and make the changes, and yet we are also afraid collaboratively to get together, and this is the teaching hospitals and the universities, not perhaps the thing that comes to mind first, but I believe it substantially impacts health care expenditures because, quite frankly, one of the most cost-ineffective items is, for example, to spend 7 years and a lot of money training a neurosurgeon that the community doesn't need who has to look around to find work.

If I had my choice, I would like to have—I know it sounds anticompetitive, and I recognize that, but I would much rather have less doctors so that everyone was a little too busy so we weren't looking to generate any additional work.

Mr. JOHNSON. If I could follow up, there are two problems today, I think, in permitting doctors to create cost-efficient ways to deliver care. One is the chilling effect that four or five major criminal antitrust actions have had on physicians. In some cases, there may have been price-fixing. In some cases, the actions may have been legitimate in terms of some enforcement.

But the net effect in the gray areas of antitrust laws of telling physicians that they will go to jail if they collaborate even in markets that haven't heard of HMO's before, where physicians haven't even thought through or understand the competitive implications, has caused most antitrust lawyers to tell their physicians who want to create competitive alternatives that we have to be extraordinarily careful even if we are within the letter of the antitrust laws.

Senator HATCH. You can never be sure.

Mr. JOHNSON. You can never be sure. Clarification is critical because of this. The second thing is physicians do practice in smaller groups today, like Dr. Corlin. That is changing, and it will change and we are turning the AMA around to help physicians change in the competitive environment. We support that. That is our role, is to educate and help in that regard, but it isn't a step that can happen overnight.

Today, a physician's choice to integrate is to merge his practice or her practice entirely, just to quit, to give up and to join a large group, or it is to become an employee of an insurance company or an HMO, or it is to do these fully integrated ventures which the Federal Trade Commission defines in ways which we do not think are clear and are far too narrow.

What we want is for those physicians to have another alternative, to begin to get together, to begin to organize in ways, when they don't have market power, that do have legitimate procompetitive purposes and effects. Today, they don't have that option. They have to go the whole route or nothing, and that means physicians are not going to be involved in creating the kinds of systems that will be more efficient and will be competitive. We want clarification, not exemption.

Senator HATCH. Thank you. Mr. Brennan?

Mr. BRENNAN. Senator, let me answer first in the short term. I would like to underscore something Professor Havighurst said that PMA is not seeking either a change in the antitrust laws or even an exemption from the antitrust laws. What we are seeking is merely a statement from the Department of Justice of their enforcement intentions in a very limited area of pricing and for a very limited period of time. That is something far short of an exemption from the antitrust laws.

Senator HATCH. Right.

Mr. BRENNAN. In the long term, we don't feel there is any need to make any change in the antitrust laws. We are committed to the competitive marketplace and to the disciplines embodied in the antitrust laws. We look forward to, as an industry, operating in the competitive marketplace that managed competition suggests in which there will be a pharmaceutical plan in the basic benefit package.

Senator HATCH. Well, I have to say that I am not as convinced as some in the administration and some around here that managed competition is nirvana or the answer to all questions. I am certainly keeping an open mind on it and I am studying it just like everybody else, but I am interested in ideas on antitrust here and what should be done because I personally feel there have to be some changes in order to have more specificity, more definitive

knowledge so that you can know what guidelines you are supposed to live within and then live within them, and also so that we can heighten the ability to have what President Bush called coordinated care, what others are calling collaborative efforts, et cetera, et cetera.

It seems to me that it makes sense that we do that and that we don't spend all our money, like the poor little outfit, Ukiah, defending ourselves in lawsuits when that money could be going for the better purposes of taking care of the sick and the needy.

We in Utah, for instance, are going through an untold amount of expense out there on something that probably could be resolved just by good-faith efforts on the part of all concerned, and it is costing a State that doesn't have a lot of money an arm and a leg at a time when it really could utilize those funds in a far better way.

Let me just ask you one other question, Mr. Brennan. I understand that the Clinton administration, similar to my request last year, asked that your member companies voluntarily limit the growth rate in prices to the growth in the CPI. As Professor Havighurst has indicated here or pointed out in his testimony, the Department of Justice business review letter does not relieve your companies from other possible antitrust actions.

Now, how will this risk affect your ability to keep prices low, and would greater certainty allow a greater ability to reduce prices?

Mr. BRENNAN. Senator, unfortunately, the Clinton administration has not suggested to the pharmaceutical industry in any kind of definite terms that price increases be restrained in any particular manner. That, quite frankly, is what we have been suggesting that the administration might do, and it is because the administration has not pursued that kind of a course that we went to the Department of Justice.

As I indicated earlier, we still think that we can compete very aggressively under a system where companies are restraining their prices across their product line in an aggressive way. Quite frankly, over the last year there has been significant reduction in price increases. The Bureau of Labor Statistics just last month, in February, issued their figures for the 12 months previous that ended in February 1993, and the manufacturers' price increases were only 4.5 percent during that period. That is down from 9.5 percent in 1989, a 53-percent reduction. That is a very significant record.

Senator HATCH. Actually, your prices as a percent of the dollar have gone down from 10 cents to about 5 cents of every health care dollar?

Mr. BRENNAN. Just about, yes.

Senator HATCH. Just about that.

Senator METZENBAUM. Senator Hatch?

Senator HATCH. Yes. Oh, my goodness, you mean my time is up?

Senator METZENBAUM. I am going to take 5 minutes more and you can take 5 minutes more or as much time as you want after that.

Senator HATCH. No. That is fine.

Senator METZENBAUM. Mr. Brennan, I didn't get a chance to ask you any questions, but the PMA has asked the Department of Justice for immunity from antitrust prosecution for an agreement among PMA member companies to limit price increases on pre-

scription drugs. As you know, Senator Pryor and I have written to the Attorney General opposing that request for the reasons that I described in my opening statement.

I have several specific concerns about the PMA's proposal. One of them is I do not believe that the price limit agreement that you proposed would be effective in reducing prices for most consumers. Specifically, you ask for immunity for an agreement to limit prices on "the entire line of a company's prescription drug products in any calendar year to an amount not to exceed the increase in the CPI."

Now, that is misleading because people think that you are talking about limiting price increases of all pharmaceuticals. You actually said in that letter that the effect would be to limit aggregate price increases for prescription drugs, but that doesn't mean that individual drugs would be limited as to the amount of the increase.

You can't expect us to believe that this is a serious proposal to hold the line on drug prices. Under your agreement, drugmakers will reduce the price for a big buyer, like an HMO, while they boost it for an individual consumer who buys through a local pharmacy, or they will reduce the price on a competitive product like aspirin while they boost it for a life-saving drug like AZT.

Wouldn't many consumers pay higher prices for prescription drugs under your proposed agreement, or isn't there a likelihood that they would?

Mr. BRENNAN. Senator, let me put this in its complete context. As I indicated, the PMA supports the early enactment of managed competition and the inclusion of a drug benefit in the standard benefit package, and we look forward to that being done at an early date and implemented at an early date. As Professor Havighurst said, and I think we all agree that the chances of prices being severely restrained throughout the health care system in that kind of a circumstance is going to be significant.

In the interim only, we are suggesting this across-the-board limitation on price increases, and that is going to have a significant impact immediately for a whole range of consumers, Senator.

Senator METZENBAUM. I am asking you, would you be willing to agree under that proposal that you would not increase the price of any specific drug more than the CPI?

Mr. BRENNAN. If every drug increase were held to the CPI, that is essentially a price-fixing scheme.

Senator METZENBAUM. It is a price-fixing scheme. That is what you are asking for. What you are really saying is we are going to hold the price down for some big buyers, but we are going to very possibly raise the price for individuals. I am asking you, if you are really sincere, if you really mean what you are saying, then would you be willing to modify your request to the point that you ask for permission to enter into an agreement that no specific drug price will be increased in excess of the CPI?

Mr. BRENNAN. I can't commit individual companies or anyone in our industry to the specific set of circumstances you are talking about, Senator, but in the business review letter context there is a back-and-forth, a discussion between the time the request is made and the time the requested is granted, and I think that that is the kind of thing that——

Senator METZENBAUM. You are missing my point, Mr. Brennan, and I am not going to let you miss my point. I am saying that your proposal is a farce, that your proposal is unrealistic, that your proposal doesn't propose anything that is meaningful for the consumer. All you are doing is coming in because the PMA has been under a lot of public pressure for the fact that prices have gone up so much, much higher than the cost of living, much higher than anything else in the economy. Your profits have increased at a much higher rate than most other industries.

Now, you come in with this thing that looks like you are going to hold prices down, but you are not saying that. I am asking you, will the PMA modify their letter to say we won't increase prices any more on any particular pharmaceutical drug that we sell; will you permit us to enter into an agreement to do that? That is really what would be meaningful.

Mr. BRENNAN. Senator, I think if this industry did that, it would bring the industry, under the terms of the *Maricopa* decision which is cited in——

Senator METZENBAUM. Don't worry about that. Let us assume that you could do it. I am asking would you do it.

Mr. BRENNAN. I can't commit my members to doing that, Senator. However, you must understand that if the members of PMA make the commitment that they have in the business review letter request, there cannot be very many patients in the marketplace where the price can go much above the CPI because, certainly, the large payers, as you just indicated—prices would have to be well at or well below that CPI figure.

Senator METZENBAUM. Mr. Brennan, my time has expired, but I would say to you that your proposal is an effort to flim-flam the American public into believing that the pharmaceutical manufacturers are prepared to hold down prices, and it just ain't true, it just ain't true.

Mr. BRENNAN. Senator, we think it is a good-faith effort and we want to pursue it.

Senator METZENBAUM. It is not a good-faith effort. It is a mirage, it is a mirage. If you come in modifying it and say you will hold down prices, and you want an agreement so you can hold down prices for every drug, that I would say would be a good-faith effort.

Senator Hatch, I leave you to conclude the meeting.

Senator HATCH [presiding]. Well, thank you, Senator Metzenbaum, and I think I will conclude it with just some facts here. You know, there is a debate here whether we should set prices in the health care field. I would like anybody to point out any instance where price controls have really worked in a free market society like ours.

In your case, health care costs are skyrocketing. They are going up 13, 14 percent a year, no question about it. Since the passage of Medicare and Medicaid in 1965, the share of our economy devoted to health care has more than doubled, right?

Mr. BRENNAN. Right.

Senator HATCH. And as you know, unless major changes are made, by the year 2020 one out of every three dollars will be used for health care in our whole society and we won't have any money for any other social programs at all if that is the way it continues.

But, yet, where have drugs remained with regard to constant figures?

Mr. BRENNAN. Well, the percentage of the gross domestic product for pharmaceuticals has remained essentially constant over the last 30 years.

Senator HATCH. And that is, what, about ½ of percent, right?

Mr. BRENNAN. Yes.

Senator HATCH. While everything was going up, pharmaceuticals remained at about ½ of 1 percent, and they have remained constant at that in spite of some of these anguished cries by some of our liberals in Congress that drug prices are going out of control, even though we all feel that they are high.

When you talk about cost comparisons, there is a lot to be said there as well as to what you can do by good drug therapy. You talk about the average cost of creating a drug—$231 million we used a couple years ago or last year. I think OTA has it up over $300 million for creating a marketable drug, with 4,000 misses.

Mr. BRENNAN. Yes, near $350 million.

Senator HATCH. I brought out before that if you take drugs as a percentage of total national health care expenditures, over the last 25 years the share of health spending devoted to drugs has been cut almost in half, from about a dime to about a nickel of every dollar—health care dollar, that is. Am I wrong on that?

Mr. BRENNAN. That is correct.

Senator HATCH. Well, something is wrong here because I hear all this screaming and shouting about how rotten the pharmaceutical companies are, and yet the facts don't seem to say that, even though anybody who buys drugs today knows that they are expensive.

If you look at it on a basis of parity dollars between our country and other countries, where would the United States fall, at the top of the list as far as drug costs are concerned, or at the bottom of the list or somewhere in the middle?

Mr. BRENNAN. In terms of the developed world, Senator, just about in the middle.

Senator HATCH. About in the middle. Well, some of our international neighbors spend more on pharmaceuticals, some spend less, I take it.

Mr. BRENNAN. Correct.

Senator HATCH. But we are about in the middle?

Mr. BRENNAN. That is right.

Senator HATCH. OK. So there is nothing extraordinary about cost per patient with regard to pharmaceuticals in this country?

Mr. BRENNAN. There certainly isn't. Measured that way or measured in terms of the purchasing power of the patient that it takes to buy pharmaceuticals, it is very competitive.

Senator HATCH. Well, what about drug pricing measured in terms of the Producer Price Index? Where are drugs with regard to that?

Mr. BRENNAN. Well, in terms of the Producer Price Index, I indicated a moment ago 5 years ago price increases were going up about 9.5 percent. There was some criticism of that. The industry responded to that criticism and over the last 12 months prices have increased only 4.5 percent. That is a pretty admirable record.

Senator HATCH. Well, as I understand the Producer Price Index, according to the Bureau of Labor Statistics data, between 1989 and 1991 the relative price of pharmaceuticals dropped by two percentage points.

Mr. BRENNAN. That is correct.

Senator HATCH. Well, you know, the thing that bothers me is I hear all these anguished cries and I have to say that everybody is concerned about costs of medical care and treatment, but the facts just don't bear out that the pharmaceutical industry as a whole has been gouging the American public. If you really look at these facts and statistics, you have got to say that you are spending $11, $12 billion a year in research and development. You are developing some cures that basically, compared to surgery, save taxpayers an awful lot of money in Medicaid and Medicare funds. Your prices have remained basically constant as a percentage of health care dollars.

You know, it is easy to beat up on business up here and complain because if you go buy some of the drugs at the drugstore, they seem to be very expensive. Yet, as a percentage of what really is happening, you have pretty much maintained constancy over the years.

Mr. BRENNAN. Right.

Senator HATCH. And for somebody to come in—now, the 31 top drug companies produce, what, about 75 percent of all the pharmaceuticals in this country?

Mr. BRENNAN. Yes, between 75 and 85 percent.

Senator HATCH. How many of those made money last year, all of them?

Mr. BRENNAN. I think they all made money, but if you follow Wall Street you will see they didn't make nearly as much as they have in the past, and research budgets and all other expenditures are being looked at very carefully to see how they can be continued.

Senator HATCH. And if you look at the companies that are in the other 25 percent, they don't all make money, do they?

Mr. BRENNAN. No.

Senator HATCH. A lot of these biomedical companies are——

Mr. BRENNAN. Most are not making money.

Senator HATCH. And most of them are going through heavy expenditures to try and develop really life-saving drugs that might make the difference between health care responding well and not responding well in the future.

Mr. BRENNAN. Right. Their research budgets are probably well over 50 percent of their expenditures.

Senator HATCH. Well, I only wanted to go through a few of those things not to repeat what we debated a year ago or 2 years ago—I can't even remember—but, you know, it bothers me when these people start talking about price controls because I know if you go to price controls, I don't see how quality can help but come down, and I don't see why that wouldn't have a deterrent effect on research and development which is critical to us in the future of this country and the future of health care in this country.

I don't see how in the world we are going to solve problems like AIDS or the new strong strain of tuberculosis or a whole wide variety of other health maladies if we don't continue to spend the

money and make the efforts to try and get the answers to some of these big problems.

So it is easy to beat up on some of these companies because some of our people around here don't want anybody to make a profit, or at least a reasonable profit. They just want you all to do this in the altruistic interests of the American population. That is a wonderful thing to try and do, I am sure, but you can't stay in business if you do just that, right?

Mr. BRENNAN. Correct. We are doing an awful lot for charity, as you know, Senator, and making drugs available to people, to indigent patients, for no cost whatsoever.

Senator HATCH. This is a little off the subject, but one last thing. I noticed that sometimes offshore prices of drugs—the same drug that costs more in the United States costs a lot less in other countries. If price controls go into effect, what about those Third World countries that can't afford the pharmaceuticals?

Mr. BRENNAN. Well, that whole situation would have to be reevaluated, Senator.

Senator HATCH. They are going to have to pay the high prices, too, aren't they, a lot of these countries that can't afford it?

Mr. BRENNAN. Right.

Senator HATCH. And the only reason you can do that in some instances is because once you have gotten through the 4,000 misses and you have a marketable drug, you have to recoup that $231 million or $369 million, or whatever the price is, in order to be able to continue research and development and develop other drugs to keep your company going.

But sometimes, once you have reached that point where you have a marketable drug, the actual costs of making that drug really are not very high, unless you factor in getting your money back so you can continue research and development, so you can continue to find more cures. Sometimes you can, for Third World countries, put those drugs out at a very low cost because you are just kind of writing it off in that area. You are not trying to recoup your costs from those countries.

But if you can't do that, then those countries are going to have to pay the higher price, too, and they are going to wind up not being helped. Isn't that true? I mean, that is where we are headed, isn't it?

Mr. BRENNAN. That whole marketplace would be affected.

Senator HATCH. Isn't that where we are headed with this kind of talk?

Mr. BRENNAN. Price controls disturb the entire market, Senator, in very artificial ways and countries of that sort would definitely suffer.

Senator HATCH. I have had pharmaceutical company heads tell me that they are so sick and tired of being beaten up in this kind of a manner, in this populist manner, that they are just going to charge all these Third World countries the same price as anybody else, which means there won't be any drugs in those countries. Have you heard that?

Mr. BRENNAN. No, I haven't, Senator, but you may have a different channel of communication.

Senator HATCH. I have heard that and that is what they said is going to happen if we keep playing this populist game and we don't look at economics and don't look at what really needs to be done.

Well, I just wanted to bring a few of those points out because I think they are pretty important points. There is a lot more that could be said, but I get a little tired of the price controllers around here who seem to ignore the fact that this country has produced so many important pharmaceuticals and has produced the greatest health care delivery system in the world without price controls. Even though it is expensive, even though it is difficult for us all, we at least have a country that provides the best health care of any country in the world.

Well, we want to thank all of you for being here. Sorry to preach to you at the end, but my friend from Ohio inspires me regularly. Thanks so much.

[Whereupon, at 1:09 p.m., the subcommittee was adjourned.]

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